Recommendation to the Governor on Proposed Rules for Workers' Compensation Reform 2005

Department of Labor & Industrial Relations

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Title 12, Chapter 10, Workers' Compensation Administrative Rules
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EXECUTIVE SUMMARY

A. Overview

Hawaii's current workers' compensation system is costly and ineffective. Year after year, experience tells us that it is taking too long to return injured workers back to meaningful employment, and Hawaii's employers are not paying affordable workers' compensation insurance premiums. In fact, Hawaii's employers pay the fourth highest premiums in the nation, paying an average of $3.73 for every $100 in wages reflecting an increase of 25 cents per $100 in wages. The system has little safeguards or effective procedures in place to eliminate, or even minimize, abuse. Hawaii's workers' compensation system was highlighted as one of only eight states to receive a failing grade in a recent national survey – a ranking that will surely stifle future economic growth and prosperity unless we immediately take meaningful action.

The Department of Labor and Industrial Relations' ("Department") plan to reform Hawaii's workers' compensation system evolved into a three-prong approach. The first phase involved identifying the cost drivers and areas for improvement. In January 2004, the Department published and distributed to legislators a comprehensive report detailing the driving factors of workers' compensation costs and recommendations to address those issues. (This report is posted on our website at http://www.hawaii.gov/labor).

The second phase of our reform action plan was to improve the Department's operations. Our study established that we needed to modernize our workers' compensation hearings process to bring greater efficiency, transparency and accountability, while ensuring that injured workers are provided with quality medical care based on medical evidence. We are now making these changes to the Department's operations and recommending the adoption of the administrative rules discussed in this report.

The third phase involved submitting an omnibus workers' compensation reform bill to the 2004 Legislature that addressed several key cost drivers, while ensuring that injured employees are entitled to quality medical care and necessary benefits. We presented a comprehensive package of changes because we recognized there is no silver bullet, or single initiative, that will provide relief to our system. Yes, eliminating fraud – regardless of who commits it – must be accomplished, but addressing the issue alone will not fix our broken system.

The Legislature last year debated our bill but was unable to achieve consensus. None of our proposals were passed by the Legislature last year.

This year, the administration submitted a similar omnibus bill that incorporates changes that addresses the concerns raised by the legislators. The administrative rules proposals and the legislative proposals are intended to work in hand-in-hand in addressing the cost drivers and achieving the same goal – to provide Hawaii's injured workers, in the most efficient and cost effective manner, quality medical care, rehabilitation services and the benefits needed so they can return to work as soon as they

are able. In turn, this will likely result in lower workers' compensation costs for employers.

In order to achieve true workers' compensation reform, all three components of the system (departmental procedures, administrative rules, and legislative initiatives) must improve. The Department has the authority and is making strides in improving two of the three of components. The third component, enacting reform legislation, can only be accomplished by the will and action of the Legislature.

B. Goals of Proposed Administrative Rules

One of the major problems with Hawaii's workers' compensation system is the length of time it takes for injured workers to receive medical treatment and necessary vocational rehabilitation services to enable them to promptly return to meaningful employment. Last year, an independent organization gave Hawaii's system an "F" grade, primarily because 22.6 percent of workers stayed off the job for more than 30 days in 2002 - much longer than in other states. This is primarily the result of the system moving at a sluggish pace in resolving disputes and the increased litigation over how an injured worker should receive treatment. The proposed rules attempt to address these concerns.

- Claims' Hearings and Resolution Process

First, the rules would improve the efficiency of the hearings process, which will result in more cases being resolved in a timelier manner. They also would guarantee employees an expedited hearing in certain situations where the insurance carrier or employer is unreasonably denying a work-injury claim. There is currently no such rule. The proposed rules also provide the employee and employer the option to resolve their disputes through the alternative resolution process, similar to arbitration hearings and the mediation process that have proven successful in resolving disputes in other areas of the law.

- Medical Guidelines

Second, the proposed rules also would ensure that injured workers are being treated based on the most current medical "best practices." The proposed rules also would allow doctors the flexibility to treat an injured worker more extensively than what the guidelines may indicate, provided that there is an objective medical justification. This would ensure that diagnosis and treatments for workplace injuries conform to practices that objectively seem to have the best chance of producing the best outcomes.

Twenty-one states rely on treatment guidelines. California enacted guidelines as part of its major workers' comp reform package in 2004. A University of California-Berkeley study estimates that California will realize 36.7 percent, or $3.1 billion, in cost savings to its system due to those guidelines. Potentially, Hawaii could realize the same cost savings - $98 million - to the system should the proposed rules go into effect.

- Vocational Rehabilitation

Finally, the proposed rules relating to vocational rehabilitation under workers' compensation are sought to establish procedures to simplify and clarify the rules relating to vocational rehabilitation. These amendments were intended to ensure injured workers receive necessary vocational rehabilitation services in the most cost-effective and efficient manner. These amendments were intended to encourage the employee, medical provider, vocational counselor and the employer to work cooperatively in designing and monitoring the employee's vocational rehabilitation program. It also intended to restore an injured worker's earnings capacity, as nearly as possible, to the level which the worker was earning at the time of injury, and to return the injured worker to suitable work in the active labor force as quickly as possible in a cost-effective manner.

C. Department's Recommendation

A public hearing on the proposed rules was held on February 7, 2005, during which the Department received approximately 230 testimonies. After considering the testimonies submitted, the Department is recommending the adoption of the majority of the proposed rules with the exception of the rules pertaining to vocational rehabilitation.

Based on the number of concerns and differences of opinions raised in the testimonies opposing the proposed amendments to the vocational rehabilitation rules, the Department recommends that these rules be deferred. In the next few months, the Department will continue to work with the various stakeholders to attempt to resolve the concerns and differences of opinions submitted at the hearing, and revise the Department's proposals for changes to the vocational rehabilitation rules.

In summary, the Department recommends the adoption of the following proposed rules:

CLAIMS' HEARINGS AND RESOLUTION PROCESS

Recommend for Adoption	Justification
1. Section 12-10-1 Definitions	
a. "Able to resume work"	Removes superfluous language.
b. "Attending physician"	Insure that any attending physician be a physician as defined in section 386-1.
c. "Days"	Clarify that if the statute and rules do not specify "working days", then "calendar days" should be used.

d. "Disciplinary action"	Clarify disciplinary action as used in section 386-3. Codifies existing case law defining "Disciplinary action."
e. "Good Cause"	Clarify "Good cause" as used in the statute and administrative rules.
2. Section 12-10-65 Discovery	Provide clear notice of rules and procedures for discovery in the workers' compensation process to promote fairness, transparency, and efficiency.
3. Section 12-10-66 Alternative resolution	Clarify how dispute resolution and mediation may be used to resolve dispute or claims in the workers' compensation system.
4. Section 12-10-67 Witness fees	"Witness fees" is repealed to consolidate all rules relating to the "Discovery" process.
5. Section 12-10-69 Attorney's fees	Provide objective standards in determining the amount attorneys representing claimants should be compensated
6. Section 12-10-72.1 Hearings process	Provide a hearings process that is transparent and provide all parties with a clear understanding of the process and timetables.
7. Section 12-10-94 Self-insurance	Provide objective guidelines to determine qualifications for self-insurance.

MEDICAL GUIDELINES

Recommend for Adoption	Justification
1. Section 12-15-1 Definitions "Evidence based"	Ensure that treatment plans submitted by health care providers are supported by scientific medical evidence to ensure that the injured

	employee is properly treated based on medical "best practices."
2. Section 12-15-30 Provider of Service Responsibilities	Clarify that providers of service shall follow the treatment guidelines in section 12-15-32.
3. Section 12-15-31 Who may provide services	Clarify that all treatment and prescriptions shall be in writing and in accordance with sections 12-15-30 and 12-15-32 relating to providers of service and their responsibilities.
4. Section 12-15-32 Physicians	Provide frequency of treatment guidelines for all providers of service.
5. Section 12-15-34 Providers of Service other than Physicians	Repealed to provide consistency and clarification with section 12-15-32.
6. Section 12-15-85 Rules for allowable fees…	Verify that the provider is treating a work injury and billing in accordance with the workers' compensation law and related rules.

VOCATIONAL REHABILITATION

Recommend for Adoption	Justification
None.	Due to the number of testimonies and numerous concerns raised, the Department will defer on these rules. The Department will continue to work with the various stakeholders to discuss the concerns and differences of opinions submitted at the hearing and develop revised administrative rules for public hearing to be scheduled in late 2005.

Section I. INTRODUCTION

The Department's plan to reform the workers' compensation system evolved into a three-pronged approach. The first phase involved identifying the cost drivers and areas for improvement. In January 2004, the Department published and distributed to Hawaii legislators and the public a comprehensive report, detailing the driving factors of workers' compensation costs in Hawaii, and recommendations to address those issues. This report is posted on the Department's website at www.hawaii.gov/labor

A. Goal of Hawaii's Workers' Compensation System and Reform Efforts

Hawaii's workers' compensation system is a delicate balance of social and economic considerations. On one hand, injured workers have a legitimate right to be compensated when they are injured as a result of their employment, and on the other hand, the cost of workers' compensation must be reasonable in order to achieve prosperity.

Currently, that balance is not being achieved as Hawaii's employers' are paying one of the highest premiums in the nation, and experiencing difficulty in finding insurers who are willing to provide coverage. Reform efforts are needed in the system. If left unchecked, the system itself will serve as a real barrier for existing businesses to expand and discourage new businesses that offer high paying jobs to do business in Hawaii.

B. The Administration's Three-Pronged Approach to Reforming the Hawaii's Workers' Compensation System

In early 2003, the Department began the task of identifying the problems prevalent in Hawaii's workers' compensation system to recommend changes. In determining what changes were necessary, the Department undertook the following initiatives:

1. Reviewed the available legislative history and testimony of all major workers' compensation initiatives from 1915 to the present.

2. Reviewed the following studies, audits, and recommendations from the State Auditor, Legislative Reference Bureau, and prior Administrations:
   a. Report No. 1, 1963 "Study of the Workmen's Compensation Law in Hawaii";
   b. Report No. 91-12 "Study of Administrative Adjudication in Hawaii";
   c. Report No. 97-3 "Audit of the Special Compensation Fund of the Workers' Compensation System";
   d. Report No. 01-03 "Audit of the Workers' Compensation Payment Process in State Agencies";
   e. Report No. 02-15 "A Report on the Revolving Funds, and Trust Accounts of the Department of Human Resource Development, Department of Labor and Industrial Relations, Department of Public Safety, and Department of Taxation";
   f. Report No. 02-07 "Management Audit of the Disability Compensation Division and a Study of the Correlation Between Medical Access and Reimbursement Rates Under the Medical Fee Schedule";

g. Hawaii Workers' Compensation Closed Claim Study of 1993, by Tillinghast, a Towers Perrin Audit Company;
h. Report to the Legislature on Act 234, Regular Session of 1995; and
i. Report to the 2002 Legislature on Coordinated Care Organizations - Act 166, 1998.

3. Reviewed studies, audits, and recommendations from the following organizations:
   a. Workers' Compensation Research Institute ("WCRI");
   b. International Association of Industrial Accident Boards and Commissions ("IAIABC");
   c. RAND Corporation;
   d. Work Loss Data Institute State Report Cards for Workers' Comp 2004;
   e. National Council on Compensation Insurance ("NCCI");
   f. University of Massachusetts and Robert Wood Johnson Foundation's "Workers' Compensation Health Initiative";
   g. University of California-Berkeley;
   h. United States Department of Labor;
   i. National Center for Biotechnology Information;
   j. National Academy of Social Insurance;
   k. Hawaii Insurers Council / First Insurance;
   l. Kaiser Permanente; and
   m. Oahu Transit Service / The BUS

4. Participated in the Chamber of Commerce of Hawaii's Workers' Compensation Working Group.

5. Formed a working group of several experienced, respected and prominent workers' compensation attorneys representing the International Labor Workers Union ("ILWU"), Hawaii Employers Mutual Insurance Company ("HEMIC"), Chamber of Commerce, and non-union employees. The Director of Labor and Industrial Relations ("Director") asked the group to independently review the current language of the Department's administrative rules and propose amendments or new language to streamline and improve the Department's operations. *To date, the group has not provided proposed language or suggested amendments to the Director.*

6. Maintained an open door policy and listened to representatives of labor and management organizations, and numerous service providers of the workers' compensation system, including medical doctors, chiropractors, vocational rehabilitation counselors, attorneys, and members of the insurance industry.

7. Spent countless hours analyzing the workers' compensation systems and experiences of other states.

The second phase of the reform plan was to improve the Department's operations. The Department's study established that modernization of the workers' compensation hearings process was needed to bring greater efficiency, transparency and accountability,

while ensuring that Hawaii's injured workers are provided with quality medical treatment based on scientific medical evidence. The Department is making these changes by proposing changes to its administrative rules.

As part of the second phase, the Department has taken internal steps to eliminate unwritten rules such as the $15,000 "wash rule" that held employers hostage to a minimum dollar amount for settlements irregardless of the nature of the injury or whether or not the claimant had already agreed to a lower settlement amount. The Department has also begun the process of allowing electronic submittals of paper work to expedite claims, as well as "double booking" hearings to reduce the wait time to resolve claims.

The third phase involved submitting an omnibus workers' compensation reform bill to the 2004 Legislature that addressed several key cost drivers, while ensuring that the employee is entitled to quality medical care and necessary benefits. The Department presented a comprehensive package of changes because it recognizes that there is no silver bullet, or single initiative, that will provide relief to the system. Addressing fraud -- regardless of who commits it -- must be accomplished, but addressing this issue alone, will not fix the system or bring relief to Hawaii's small businesses.

None of our initiatives are intended to reduce benefits and payments injured workers are entitled to under our workers' compensation laws.

C. Social Contract between Hawaii's Workers and Employers

Prior to the Hawaii State Legislature enacting the Workers' Compensation Law of 1915, Hawaii's injured workers were required to seek claims for compensation and medical treatment costs for work-related injuries through Hawaii's judicial system. This process involved considerable uncertainty and unpredictability for both employees and employers as injured workers often faced significant challenges within this system. Despite minimal resources, employees were required to meet a higher "burden of proof" to prove a workers' compensation claim in Hawaii's judicial system.

Essentially, an injured worker had to prove that their employer was negligent in the industrial accident or illness that befell the employee. The uncertainty and unpredictability of the judicial system arose when injured workers were unable to meet their "burden of proof" by the employer showing that the employee was negligent, "assumed the risk," or that the injury was caused by a fellow employee. On the other hand, if the employee did prove that the employer was negligent, the employer was held liable for a large monetary damage award which affected the health and stability of their existing business and adversely affected the employment of other employees.

The basic rationale for Hawaii's workers' compensation law is that it provides benefits to the employee as an exclusive remedy on a no-fault basis. The employee relinquishes the opportunity to sue the employer for damages in court, and the employer relinquishes the opportunity to avoid paying anything to the employee. Additionally, the employer also agrees to be at a distinct disadvantage in contesting whether an injury sustained by an employee is work-related or not. Under the "social contract", Hawaii's presumption

clause favors employees. Any claim for injury is presumed to have occurred at the workplace, and therefore, the worker is entitled to workers' compensation benefits. Presumption can only be overcome by "substantial evidence" provided by the employer. In theory, this arrangement, or "social contract" is designed to benefit both workers and employers in that it protects employees from becoming impoverished or unable to obtain treatment after a work-related injury, and protects Hawaii's employers from large judgments. Without the workers' compensation legislation, it would be difficult for workers to receive treatment and benefits because of the lack of financial resources to litigate a claim against their employers.

D. Brief Legislative History of Workers' Compensation Law in Hawaii

The Original Act of 1915 (Session Laws of Hawaii 1915, Act 221)

The Hawaii Territorial Legislature adopted the State's first Workers' Compensation Law in 1915. The Workers' Compensation Law was enacted to ensure that employees who were injured or disabled on the job were provided with medical treatment and fixed monetary awards (indemnity). This law was Hawaii's first "no-fault" legislation in that it mandated there be a presumption that an employee's injuries were "work-related", while prohibiting an employee from filing civil actions against the employer for work-related injuries or illnesses.

The Act covered personal injury by accident arising out of and in the course of covered employment, including injury caused by the willful act of a third person directed against an employee because of their employment. The Act excluded self-inflicted injury caused by the employee's or another person's willful intention or by their intoxication. Death resulting from injury within six months was covered.

Under the current law, an employee sustaining a work-related injury or illness is entitled to medical treatment, wage loss benefits, permanent disability indemnity, disfigurement and death benefits. Any employer, including the State and County governments, employing one or more workers is required to provide workers' compensation coverage.

1937 Amendments (Session Laws of Hawaii 1937, Act 66 and Act 237)

In 1937, the Legislature introduced and adopted Act 66 to facilitate the employment of disabled workers. If an employee who had previously incurred a permanent total disability through the loss of a hand or foot sustained a compensable accident resulting in the loss of another hand or foot, or if having lost sight in one eye, they lost sight in the other, the employer or their insurer was liable only for compensation of the permanent partial disability caused by the subsequent injury. The employee remained entitled to benefits for total permanent disability, but the remaining balance was to be paid out of a **newly created special compensation fund** collected from payments imposed in death cases where the deceased employee left no dependents.

Additionally, Act 237, effective on January 1, 1940, reorganized the administration of the Workers' Compensation Act while also **creating the Department of Labor and Industrial Relations**. The chief administrative officer of the Department was designated as the Director of Labor and Industrial Relations. The Act placed the Bureau of Workmen's Compensation under the immediate supervision of an Assistant Director. An appeals board for each of the counties was also established. The Director was authorized to exercise original jurisdiction over all compensation cases by assuming the powers formally vested in the Industrial Accidents Boards. Appeals from the decisions of the Director were provided either to the Labor and Industrial Appeals Board for cases from the City and County of Honolulu, or to one of the three Industrial Accident Boards for cases arising in the other respective counties. A further appeal with a right-to-jury trial was likewise provided, with the jurisdiction lying with the appropriate circuit court.

1963 Amendments (Session Laws of Hawaii 1961, Act 64, Act 115, and Act 152)

In Retrospect, Prior to 1963

The Legislative Reference Bureau obtained the assistance of **Professor Stefan A. Riesenfeld** from the University of California – Berkeley to conduct the examination and recodification of the workmen's compensation statute. **Professor Riesenfeld is widely credited with rewriting the State's workers' compensation laws into its present form.** His analysis of Hawaii's statutes found it to be largely inconsistent with itself, stating that the law bore, "The telling marks of patchwork, and many incongruities had crept into the once fairly consistent scheme of legislation."

In his report to the Legislature on behalf of the Legislative Reference Bureau, Professor Riesenfeld recommended the following four major proposals:

1. The Workmen's Compensation Division should be organized to provide for the initial hearing of contested cases by independent hearings officers and for the review of cases by a single expert appeals board;
2. Compensation insurance rates should be established by a properly constituted expert board;
3. Rehabilitation, both therapeutically and vocationally, should be accepted as one of the principle goals of the workmen's compensation program and new emphasis given to achieving this goal; and
4. Necessary steps should be taken to reestablish and ensure the continuing solvency of the special compensation fund.

The amendments of 1963 were expansive and largely adopted and incorporated into law proposals number 3 and 4, while proposal numbers 1 and 2 would be incorporated in later legislative sessions.

Additionally, the 1963 amendments provided increased benefits for permanent partial disability ($25,000 maximum increased to $35,000), and rehabilitation ($1,000/case maximum increased to $5,000), and death benefits to an unmarried child incapable of self-support (to be paid for life). Further, the Legislature also amended the law to

provide coverage to off-duty police officers injured, disabled, or killed while engaged in the apprehension of violators of the law or in the preservation of peace, deemed to be caused by accidents arising out of and in the course of employment.

The most important result of the recodification was the clarification of certain provisions of the workers' compensation law that had been widely criticized as "litigiously prolific" by several courts, including the Supreme Court.

One year later, the United States Department of Labor – Bureau of Labor Standards rated Hawaii's workers' compensation law as the most liberal workmen's compensation law in the United States. (See Bulletin 212, Revised 1964)

1995 Amendments (Session Laws of Hawaii 1995, Act 218, Act 231, and Act 234)

1915, 1963, 1985, and 1995 signify the four different years that the Hawaii State Legislature undertook drastic revisions to the State's workers' compensation law. In 1995, several hundred individual businesses and employer organizations formed the Haku Alliance to lobby the Legislature for significant reform of the state's workers' compensation system. The system had become one of the more costly systems in the nation and was crippling Hawaii's business community.

The reform was primarily targeted at controlling medical costs by establishing a medical fee schedule, which generally limits the reimbursement rate for medical services at 110% over Medicare. This Act also provided clear guidelines for what constitutes fraud, limited provider care, and provided penalties and incentives for safety and health programs to reduce workplace injuries.

The amendments also established the special fund for the administration of workers' compensation insurance in the Office of the State Insurance Commissioner to administer workers' compensation insurance. Additionally, the reforms also enacted an assigned risk pool for high risk industries that were unable to obtain insurance due to their risk.

The Legislature also mandated that the Department of Labor and Industrial Relations and the Insurance Commissioner do a comprehensive feasibility study of coordinated health care delivery systems for consideration by the Legislature as a potential alternative to the current workers' compensation system.

1996 Amendments (Session Laws of Hawaii 1996, Act 260 and Act 261)

The second attempt to control workers' compensation costs occurred one year later in 1996 with the enactment of Act 261, which established the Hawaii Employers' Mutual Insurance Company ("HEMIC"). The Legislature found that despite the reforms passed in 1995, many of Hawaii's small businesses were unable to find affordable insurance and were being unfairly placed in the State's assigned risk pool, which was established for high-risk employers. HEMIC was created to provide workers' compensation coverage to not only the high-risk employers, but to those small business employers who were unable

to obtain insurance otherwise. In 1996, the State's assigned risk pool had 30% of Hawaii's businesses.

Additionally, Act 260 sought to undo the amendments of Act 234 of 1995 which amended section 386-26, HRS, "Guidelines on Frequency of Treatment and Reasonable Utilization of Health care and Services". In 1995, this section was amended to provide treatment guidelines and utilization in which the "…frequency and extent of treatment shall not exceed the nature of the injury and process a recovery requires…" In 1996, the Legislature repealed the amendment and mandated that the Director of Labor and Industrial Relations develop treatment and utilization guidelines for medical providers.

However, instead of developing the treatment and utilization guidelines mandated by the Legislature, the Department instead adopted into the administrative rules the original language repealed by the Legislature: "…frequency and extent of treatment shall not exceed the nature of the injury and process a recovery requires…"

E. Hawaii's Workers are Entitled to One of the Richest Package of Benefits in the Nation

Hawaii's workers' compensation law provides injured workers some of the richest benefits in the nation. While some states such as California provide for no vocational rehabilitation, Hawaii's system allows the employee to select his or her own vocational rehabilitation plan with little input from the employer. The employee may also set up his own business and there is no time limit to complete the vocational rehabilitation plan. Additionally, many states such as Alaska, Connecticut, Idaho, Florida, Idaho, and others, cap the amount of weeks an injured employee can collect temporary total disability payments or offset the payment, while Hawaii's provides no limit a person can be deemed temporarily disabled and therefore collect temporary disability benefits.

F. The California Experience

During the mid-1990's, California began to experience rapidly escalating premiums and direct costs for workers' compensation. Their experience is worth noting because as workers' compensation costs rose, it dramatically affected the state's economy as jobs were driven away from California. The high cost meant that workers' compensation became a "poison pill" for California's economy. Insurers began to refuse to underwrite new businesses and some found themselves unable to operate in the state. Jobs were being driven from the state as companies began to relocate or expand in surrounding states such as Oregon and Nevada. Additionally, their economy began to suffer as new businesses refused to open in California, which dramatically affected job creation and raised unemployment.

In 2003, largely due to the state of their economy, California's voters recalled their Governor and elected a new one. One of the major reasons for the recall was the high cost of workers' compensation, and the Legislature and new Governor initiated major reform of their system. In 2004, the Legislature passed, and the Governor signed, a workers' compensation reform bill. A major component of that legislation was the

implementation of evidence-based, medical treatment guidelines. A study conducted by the University of California - Berkeley found that medical treatment guidelines alone would save California's workers' compensation system 36.7% in total costs.

On April 14, 2004, Governor Arnold Schwarzenegger signed California's workers' compensation reform bill and proclaimed:

> "With this great reform, I can say to everyone, California is open for business. My priority has always been to bring the jobs back, to help businesses succeed and to make our economy boom again. This workers' compensation reform will reduce the high costs that have driven jobs away from California. No longer will workers' compensation be the poison pill of our economy. Together, we are tearing down the obstacles to recovery. Businesses are watching it happen, and they are already responding. The businesses that were thinking about moving outside the state are now staying here. The businesses that were thinking about expanding are expanding here in California."

Due in large part to the reforms instituted by California, the California Workers' Compensation Insurance Rating Bureau's governing committee recently filed an advisory filing advocating a 10.4% decrease in the state's workers' compensation "pure premium rates" for policies renewing or incepting by July 1, 2005.

Section II. FUNDAMENTAL COST DRIVERS

There are three fundamental issues that drive workers' compensation costs nationwide: (1) workplace accidents, (2) administrative interference, and (3) duration.

An employer's ability to reduce and eliminate workplace injuries and illness, promptly treat and compensate the injured employee, and then return that employee to work in the most expeditious manner, significantly reduces costs. In Hawaii, employers have drastically reduced workplace injuries by 29% since 1995, yet their cost per case has increased substantially.

Administrative interference is the burden placed upon employers and employees by the Department. These burdens include antiquated processing of workers' compensation claims, outdated rules and procedures that are either unclear or unwritten, and arbitrary patterns of practice that in all, delay the resolution of claims while in the Department and adds to the cost of the claim.

In 1994, Hawaii processed 61,353 workers' compensation cases at an average cost of $5,592 per case. Hawaii also ranked third in the nation that year in workers' compensation premium rate rankings. The premium rate ranking is compiled and adjusted by the Research and Analysis Section of the Oregon Department of Consumer and Business Services and reflects the amount of money spent on premiums for every $100 of payroll wages.

In the nine years since the 1995 workers' compensation reform and through a concerted effort by employees and employers to implement safety programs that have significantly reduced workplace injuries by 28% from 1995 to 2003, there have been several significant occurrences:

- Hawaii's business community is still pleading for relief and has made workers' compensation reform their number one priority.
- The cost per case for workers' compensation has risen to an average of $6,492.
- Hawaii is fourth in the nation in premium rate rankings. (While Hawaii saw significant increases on the percentage of payroll paid to workers' compensation, Alaska vaulted ahead of Hawaii to third in the nation as its system saw significant cost increases.)
- Hawaii's businesses on an average pay $3.73 for every $100 they pay in wages.
- Local companies have shown that their premiums for workers' compensation have doubled and tripled in the last five years.
- Several insurance carriers have stopped insuring Hawaii's small employers as soon as they file their first claim.
- The insurance-rating and information agency, A.M. Best, noted that Hawaii's poor outcomes in providing prompt, quality medical care and returning the employee back to work, are being reflected in our workers' compensation insurance costs, which increased about 24% annually in 2003, compared to 2002.
- In 2002, of the workers who missed work due to a workers' compensation injury, 22.6% of the employees were out for 31 or more days. Nationally, the average cost per

case for an employee that is able to stay at work or return to work within a few days after the point of injury is $1,000 per case. In contrast, cases that extend beyond 30 days incur costs that escalate to more than $50,000.

- In a study of Hawaii's workers' compensation system, Hawaii received an "F" grade from the Work Loss Data Institute. The institute faulted Hawaii for not employing any major common-managed care strategies.
- A study from the National Academy of Social Insurance found that Hawaii's workers' compensation payments rose 6.3% in 2002. The study also found that indemnity and wage replacement payments were far greater then costs for medical care. Nationally, medical care costs are usually greater than indemnity and wage replacement costs.

Temporary Total Disability ("TTD") payments have increased substantially over the last nine years since the implementation of the 110% cap on the medical fee schedule. This means that injured workers are remaining out of work longer receiving medical attention. The duration of claims is also an issue. Claims that last longer than seven days substantially increase costs. The Department believes that three main factors have contributed to the extended length of time an employee is in the workers' compensation system:

- Departmental Interference. The Department must do a better job of expediting hearings and decision-making, as well as the processing of claims that come into the Disability Compensation System. The Department's initiatives to address this can be found on page 26.
- Healthcare providers. Although injuries do not appear to be more severe, data suggests that healthcare providers are extending the amount of time to medically treat and return an injured employee back to full employment. This results in increased TTD benefits for the employee and increased medical reimbursements for the provider.
- Vocational Rehabilitation. Allowing the employee to select his own vocational counselor without any employer involvement has created a system that extends the duration of a claim and places the employer and employee in an adversarial situation. This adversarial situation further delays recovery as the Department or the Labor Appeals Board must then adjudicate that controversy.

The proposed administrative rules seek to eliminate the Departmental interference that increases costs.

Section III. OVERVIEW OF 2005 PROPOSED ADMINISTRATIVE RULES RELATIONS TO WORKERS' COMPENSATION

The Department proposed changes to the following chapters of the Hawaii Administrative Rules pertaining to the state workers' compensation laws:

- Title 12, Chapter 10, Workers' Compensation Administrative Rules
- Title 15, Chapter 15, Workers' Compensation Medical Fee Schedule
- Title 12, Chapter 14, Vocational Rehabilitation Administrative Rules

These proposed rules present a balanced, common sense package of changes that will bring costs under control while ensuring that injured workers receive quality medical care and benefits that they need to return to work as soon as they are able to. The following is a summary of the proposed major revisions to the administrative rules.

A. Ensure Injured Workers Would Receive Their Benefits in a Timelier Manner

- All hearings would be held within 60 days after a response to an application for a hearing has been filed. *Currently, there are no rules specifying when a hearing should be held, often causing injured workers to suffer economic hardship while they wait for their "day in court".*
- The injured employee, suffering from economic hardship, will be entitled to an expedited hearing if the employer or its insurance carrier fails to respond to his application for a hearing. *Currently, there are no rules that provide injured workers the right to have an expedited hearing.*

B. Improve the efficiency of the hearings process, which will result in more cases being resolved in a timely manner

- Provide clear directives on the workers' compensation hearings process, including the discovery process, how and when hearings should be scheduled and the manner in which they should be conducted.
- These basic hearings rules modernize the hearings process, bringing predictability, transparency, and accountability in a hearings system that is plagued with complaints of inefficiency, irregularities and soaring costs.
- *Currently, there are no administrative rules governing the hearings process.* This has led to a hearings process that is unpredictable and gives the appearance of favoritism with regard to scheduling and conducting hearings.

    - Under the current system, an injured employee, representing himself (without an attorney) is at a tremendous disadvantage as our system fails to provide the employee proper notice of his rights regarding the hearings process. Without rules, the process is a moving target.

- Ensure that the injured worker will have his or her "day in court" in a timely manner. *There is no such procedure under the current rules.*

- Require all hearings to be recorded. The Department would be able to periodically review the recordings to ensure that the parties receive a fair and impartial hearing, and that there is consistency in the Department's decisions.
- The interest of keeping the hearings process lax and "informal" must be balanced with keeping the process fair, equitable and efficient. These proposed rules strike that balance.

C. Provide an Alternative Resolution of Claims

- Allow parties to resolve their disputes through a private hearings officer, which will likely lead to claims being resolved in a more timely and efficient matter.
- Similar forms of alternative resolution methods have proven to be efficient and cost-effective in resolving claims outside of the workers' compensation system.

D. Define Approval Requirements for Employers Seeking to be Self-Insured

- Self-insurance may be a viable option for many employers to reduce their workers' compensation costs.
- Currently, there are no rules which set forth the Departments' criteria to approve a company to be self-insured. This creates confusion, subjectivity, and inconsistent results.
- Provide objective standards to determine whether a company qualifies to be self-insured.
- Ensure that only those companies that are solvent and have the ability to pay for their workers' compensation claims receive the Department's approval for self-insurance. This protects the company's employees and the solvency of the State's Special Compensation Fund.

E. Define "Disciplinary Action" and Other items

- Clarify what constitutes a "disciplinary action." Any alleged injury resulting from disciplinary action is not compensable under Hawaii's workers' compensation law; however, currently there is no definition of what constitutes a disciplinary action. This change will provide employees, employers and the hearings officer with clear directives of the types of personnel action that are precluded under the workers' compensation laws.
- Codify definition used by the Hawaii Labor and Industrial Relations Appeals Board and the Department's Hearings Officers.
- Define other unclear terms used in the workers' compensation law and administrative rules for the effective, efficient, and transparent administration of Hawaii's workers' compensation laws.

F. Ensure Injured Workers Receive Necessary Quality Care Based on Evidence-Based Medicine

- Injured workers will be entitled to be treated in accordance with the evidence-based medical treatment guidelines of the American College and Occupational and Environment Medicine and the Official Disability Guidelines ("ODG").
- An employer or its insurance carrier cannot deny treatment that is based on these guidelines.
- Further, an injured worker may receive additional treatments or treatments not specified in the medical treatment guidelines if it is shown to be necessary and based on evidence-based medical treatment.
- In denying any treatment, the employer or its insurance carrier must disclose to the treating physician and employee the medically, evidence-based criteria used as the basis of the objection.
- Medical treatment guidelines will eliminate, or at least reduce delays caused by unnecessary disputes and litigation over treatment plans. It ensures that treatments are based on evidence-based medicine.

G. Ensure Injured Workers Receive Necessary Vocational Rehabilitation Services in the Most Cost-Effective and Efficient Manner

- Encourage the employee, medical provider, vocational counselor and the employer to work cooperatively in designing and monitoring the employee's vocational rehabilitation program.
- Any vocational rehabilitation plan approved by the employer will be immediately and automatically approved by the Department.
- The Department will approve plans that meet the requirement of the law, regardless regardless if it has been approved by the employer.
- Encourage employers to provide an effective back-to-work program so that employees can return to work at their wages before the injury.
- A vocational rehabilitation plan is initially limited to 104 weeks, but may be revised or extended if circumstances warrant such a change.
- The purpose for vocational rehabilitation in the workers' compensation system is "to restore an injured worker's earning capacity as nearly as possible to the level which the worker was earning at the time of injury and to return the injured worker to suitable work in the active labor force as quickly as possible in a cost-effective manner."
- Preclude vocational rehabilitation plans that are specifically designed for the injured worker to be self-employed because it is not the most cost-effective and efficient manner in returning the worker to the workforce.

To ensure efficient operation and oversight of the vocational rehabilitation program, the proposed rules provide clear standards:

- In determining whether one is qualified for a vocational rehabilitation program;
- On the goals of the vocational rehabilitation program;
- On the objection and approval process; and
- On the return to work process.

Section IV. DIRECTOR'S AUTHORITY TO ADOPT ADMINISTRATIVE RULES

A. Overview

The Legislature has given the Department's Director the responsibility to administer Hawaii Workers' Compensation Law. The Director was empowered with two methods to carry out this responsibility: (1) statutory authority under Hawaii Revised Statutes ("HRS") chapter 386 and (2) both broad and specific rulemaking authority contained in numerous provisions in chapter 386. For example, the Director has rulemaking authority in the following areas: negotiation for benefit coverage; vocational rehabilitation; computation of average weekly wages; regulation of psychologists; medical care, services, and supplies; and guidelines on frequency of treatment and reasonable utilization of health care and services. Thus, the Director has broad power to adopt rules that are consistent with chapter 386, including rules governing medical treatment.

B. Public Policy Rationale

The myriad of issues that routinely arise in the day-to-day administration of state departments cannot be totally encompassed in statutes. Consequently, departments must be given the discretion to adopt rules to improve the efficiency of department operations and thereby provide a higher quality of service to our consumers.

It is well established that administrative rulemaking comprises a significant function of a Department:

> The making of rules . . . is one of the principle functions of administrative agencies. The rulemaking function is specifically recognized in the Administrative Procedure Act.
>
> Administrative rulemaking is based on two considerations: First, rulemaking powers provide the means by which regulatory agencies formulate and interpret policies applicable to persons subject to the agency's regulation. Second, agency rules, when validly made in accordance with applicable statutory procedures, and within the scope of delegated duties, have the force and effect of law.[1]

The Legislature often provides a framework with broad public policy goals and objectives, then delegates the task of developing detailed regulations to an administrative agency. As the United States Supreme Court observed, "the objective sought in delegating rule making authority to an agency is to relieve Congress of the impossible burden of drafting a code explicitly covering every conceivable future problem."[2]

In this vein, the Director has been given the authority to make reasonable rules

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[1] Jacob A. Stein, et al., Administrative Law § 1.02[2] (2004) (footnotes omitted).

[2] Mourning v. Family Publications Service, Inc., 411 U.S. 356, 376 (1973).

"necessary for or conducive to [chapter 386's] proper application and enforcement."[3] In addition, the Director has the overall responsibility "to facilitate or promote the efficient execution of [Hawaii Workers' Compensation Law] and, in particular, shall supervise, and take all measures necessary for, the prompt and proper payment of compensation."[4]

Thus, the Legislature has not only given the Director broad rulemaking authority, but mandated that the Director make, repeal, and amend rules to facilitate and promote the efficient execution of our Workers' Compensation Law.

C. Rulemaking Authority Regarding Hearings Procedures

In accordance with section 371-8, the Director can make, amend, and repeal rules for the proper conduct of hearings, including the hearings process and discovery. ("Discovery" is the exchange of information between adverse parties.) Additionally, section 386-71 empowers the Director to "exercise all powers necessary to facilitate or promote the efficient execution" of chapter 386 and section 386-72.

The Director's authority to adopt rules was previously exercised as evidenced by the adoption of existing sections 12-10-65 and 12-10-66 effective April 30, 1981. Section 12-10-65 allows the taking of depositions and other means of discovery, while section 12-10-66 addresses the issuance of subpoenas in workers' compensation proceedings. The provisions were subsequently amended on February 11, 1991 (section 12-10-65), and November 29, 1985 and December 8, 1994 (section 12-10-66) and are currently in effect.

Consistent with the adoption of these rules dating back to at least 1981, the proposed rules regarding definitions, description of totally disabled from work, discovery, alternative resolution, attorneys' fees, the hearings process, and self-insurance are perfectly in line with the Director's existing rulemaking authority.

D. Rulemaking Authority Regarding Medical Guidelines

Chapter 386 explains that injured employees are entitled, for "so long as reasonably needed," to "medical care, services, and supplies as the nature of the injury requires."[5] In addition, such services and supplies "shall include services, aids, appliances, apparatus, and supplies as are reasonably needed for the employee's greatest possible medical rehabilitation."[6] In connection with this rehabilitation, the Director, "on competent medical advice, shall determine the need for or sufficiency of medical rehabilitation services furnished or to be furnished to the employee."[7]

To implement this and other provisions of chapter 386, the Director has specific

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[3] HRS § 386-72.

[4] HRS § 386-71.

[5] HRS § 386-21(a).

[6] HRS § 386-24.

[7] Id.

authority to adopt rules relating to the frequency of medical treatment. In fact, the Legislature has mandated that the Director "issue guidelines for the frequency of treatment and for reasonable utilization of medical care and services by health care providers that are considered necessary and appropriate under"[8] chapter 386.

Furthermore, the Legislature unequivocally provided that medical guidelines adopted by the Director shall have the force and effect of the law. Accordingly, the Legislature implemented provisions that subject providers, who fail to follow adopted guidelines, to monetary sanctions, suspension, and disqualification to practice medicine in the workers' compensation system.

In enacting section 386-26, the Legislature "recogniz[ed] the delicate balance of social and economic considerations underlying our Workers' Compensation law. On one hand, injured workers have a legitimate right to be compensated when they are injured as a result of their employment. On the other, the cost of production for employers must be reasonable in order that economic prosperity is achieved."[9] One of the problems the Legislature hoped to address with the legislation was "the lack of effective controls on the utilization of medical benefits and in the availability of other benefits."[10]

The Legislature in 1985 asked the State administration to work with stakeholders to help alleviate the problem:

> Your Committee is concerned about the increasing costs of medical and health care which currently represents approximately one-third of all benefit payments for workers' compensation. Accordingly, except for technical amendments, your Committee strongly endorses the regulatory scheme outlined in H.B. No. 463, H.D. 2, S.D. 2.
>
> Your Committee also believes that this is an area of our workers' compensation system that requires the cooperation of those most directly involved if increasing costs are to be contained. Government has always been loathe to regulate those who are performing humanitarian services. However, if we are to continue to provide the quality of care required by the humanitarian and remedial character of our workers' compensation law, we must find alternatives to reduce medical and health care costs. Regulation alone is not enough. Accordingly, your Committee requests that our state administration take the initiative to work with the various health care provider organizations along with interested employer

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[8] HRS § 386-26.

[9] H. Conf. Comm. Rep. No. 61, Haw. H.J. 929 (1985); H. Conf. Comm. Rep. No. 74, Haw. H.J. 943 (1985); S. Conf. Comm. Rep. No. 61, Haw. S.J. 890 (1985); S. Conf. Comm. Rep. No. 64, Haw. S.J. 896 (1985).

[10] Id.

and employee organizations to develop such alternatives.[11]

In response to this legislative mandate, the Director adopted rules on treatment guidelines.[12] These treatment guidelines apply to medical doctors, dentists, osteopaths, and optometrists, and doctors of chiropractic and naturopathy. The rules established a comprehensive structure for limiting the frequency and extent of treatment.

Apparently, even with the limitations set forth in the regulations, the Legislature believed medical treatments had to be further limited, because in 1995, the workers' compensation law again underwent a major overhaul.[13] As part of that overhaul, section 386-26 was revised to permit the Director, rather than the employer, to authorize additional treatments in all cases. The purpose was "to amend Hawaii's workers' compensation and insurance laws to improve efficiency and cost effectiveness in the workers' compensation system."[14]

Without explanation, in 1996, the Legislature "delete[d] the requirement that after the initial five treatments, the Director's authorization is needed for up to ten additional treatments."[15] But the Legislature preserved the Director's authority to issue guidelines for the frequency of treatment and for reasonable utilization of medical care and services. This means the Director retained authority to issue guidelines, which like the medical fee schedule, have the force and effect of law.

Under the current guidelines, physicians can provide fifteen treatments during the first sixty calendar days without authorization. Thereafter, physicians must request authorization for treatment. Similar requirements are imposed for other health care providers. Health care providers must comply with these guidelines to maintain their qualification to provide services for injured workers. However, the current medical treatment guidelines are not based on evidence-based medicine, best practices, or any objective criteria.

Under the proposed rules, the Director will adopt the treatment protocols in ODG Treatment in Workers' Comp, 3rd Edition as the presumptive prescription for health care,

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[11] H. Conf. Comm. Rep. No. 61, Haw. H.J. 929, 932-33 (1985); H. Conf. Comm. Rep. No. 74, Haw. H.J. 943, 946 (1985); S. Conf. Comm. Rep. No. 61, Haw. S.J. 890, 893 (1985); S. Conf. Comm. Rep. No. 64, Haw. S.J. 896, 899-900 (1985).

[12] See Rule §§ 12-13-38, -39, and -40 (1986).

[13] See Act 234, Haw. Sess. Laws 605 (1995).

[14] H. Conf. Comm. Rep. No. 112, Haw. H.J. 1005 (1995); S. Conf. Comm. Rep. No. 112, Haw. S.J. 810 (1995).

[15] H. Stand. Comm. Rep. No. 519-96, Haw. H.J. 1239, 1240 (1996); S. Stand. Comm. Rep. No. 2629, Haw. S.J. 1223, 1224 (1996). The Department testified in favor of deleting the provision requiring that the Director authorize all treatments after the initial five treatments, noting that health care providers, insurance adjusters, and injured worker representatives all agreed the provision was extremely burdensome to the workers' compensation program. The requirement increased paperwork for all parties with limited impact on controlling over utilization.

with the proviso that this presumption is rebuttable:

> The treatment guidelines adopted in this subsection are presumed medically necessary and correct. **The presumption is rebuttable** and may be contested by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of the injury condition.[16]

The proposed rules provide additional flexibility with "catch-all" language that allow treating physicians to deviate from the Guidelines:

> For all injuries not covered by the ODG Treatment in Workers' Comp, 3rd Edition, or in cases in which the attending physician believes that additional treatments beyond that provided by subsection (a) are necessary or that a treatment guideline different than that specified in subsection (a) is necessary, the attending physician shall mail a treatment plan to the employer at least fourteen calendar days prior to the start of the additional or differing treatments.[17]

The Guidelines are consistent with the standard of care for physicians who treat workers' compensation patients, and promulgated within the Director's rule making authority. Based primarily on an ability to make tangible and accessible the results of important and emerging medical studies to ensure appropriate patient care using best available evidence, the ODG Treatment in Workers' Comp has recently been adopted or mandated for use in various jurisdictions across the country and throughout the world. Perhaps most notable is the mandate in the State of Ohio by the Ohio Bureau of Workers' Compensation (BWC). Ohio has one of the most competitive workers' compensation systems in the nation, echoed by the recent grant of a 20 percent bill dividend to Ohio employers by the Workers' Compensation Oversight Commission, based on a recommendation from the BWC.

Simply put, the ODG Treatment in Workers' Comp is succinct, straightforward, complete, and authoritative.

E. Rulemaking Authority Regarding Vocational Rehabilitation

As explained in HRS section 386-25(a), "the purposes of vocational rehabilitation are to restore an injured worker's earning capacity as nearly as possible to that level which the worker was earning at the time of injury and to return the injured worker to suitable work in the active labor force as quickly as possible in a cost-effective manner." To help

[16] Proposed amendment to Rule 12-15-32(a) (emphasis added).

[17] Proposed amendment to Rule 12-15-32(b).

accomplish this goal, the Director was directed to adopt rules to "expedite and facilitate the identification, notification, and referral of industrially injured employees to rehabilitation services, and establish minimum standards for providers providing rehabilitation services under this section."

Twenty years ago, the Legislature commented on the importance of the Director's vocational rehabilitation rulemaking: "your Committee believes that if specific adjustments have to be made to better regulate vocational rehabilitation services, such matters are more appropriately handled through the Chapter 91, Hawaii Revised Statutes, rule making procedures to implement the provisions of this Act."[18]

The proposed vocational rehabilitation rules would provide the "specific adjustments" contemplated in the 1985 Conference Committee Report and will facilitate and expedite the proper application and enforcement of vocational rehabilitation plans "to restore an injured worker's earning capacity as nearly as possible to that level which the worker was earning at the time of injury and to return the injured worker to suitable work in the active labor force as quickly as possible in a cost-effective manner."[19]

Notably, the 1985 Conference Committee Report recognized the Director's rulemaking authority can help streamline the vocational rehabilitation process:

> [The Committee was] apprehensive about establishing durational limits on vocational rehabilitation services since such limits may have a tendency to become the minimum length of service and may actually increase rather than decrease vocational rehabilitation in most cases. Instead, [the] Committee believe[d] the better alternative for controlling vocational rehabilitation costs [was] to strengthen such items as eligibility criteria, participation requirements and the delivery of suitable vocational rehabilitation services. In this regard, [the Committee was] informed that the Department of Labor and Industrial Relations in January 1985 promulgated revised regulations to accomplish these objectives.[20]

Similarly, the Department is again attempting to adopt revised regulations to ensure injured workers qualified to receive vocational rehabilitation get such services in the most cost efficient and effective manner so that they can return to meaningful employment as expediently as possible.

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[18] H. Conf. Comm. Rep. No. 61 in Haw. H.J. 932 (1985).

[19] HRS § 386-25(a).

[20] H. Conf. Comm. Rep. No. 61 in Haw. H.J. 932 (1985).

Section V. PROCEDURAL BACKGROUND

A. Notice of Public Hearing

Pursuant to Section 91-3, Hawaii Revised Statutes ("HRS"), notice was published on Friday, January 7, 2005 that the Department of Labor and Industrial Relations' Disability Compensation Division, would hold a public hearing to amend the Administrative Rules in Chapters 12-10, 12-14, and 12-15 relating to the workers' compensation law, vocational rehabilitation under workers' compensation pursuant to section 386-25, HRS, and the Workers' Compensation Medical Fee Schedule.

The notice of public hearing was published in the following newspapers:

- The Honolulu Star-Bulletin
- The Garden Island
- Maui News
- Hawaii Tribune Herald
- West Hawaii Today

The public hearing was held on Monday, February 7, 2005, at 8:30 a.m. at 830 Punchbowl Street, Rooms 310 and 313, Honolulu, Hawaii 96813.

B. Requirements Pursuant to Section 91-2.6 HRS

Pursuant to section 91-2.6, HRS, the Office of the Lieutenant Governor is required to make available on their website the full text of an agency's proposed administrative rules or changes to existing rules. The Department's proposed administrative rules were made available from the Lieutenant Governor's ("LG") website through a hypertext link to the Department's website where the proposed administrative rules were posted.

In testimony received by the Department, the issue has been raised as to whether or not the Department and the Office of the Lieutenant Governor have fulfilled their statutory duty under section 91-2.6, HRS.

In a November 4, 2004 memorandum from the Department of the Attorney General ("AG"), the AG stated the following, "We believe that this statutory requirement is satisfied so long as: (1) the LG's website has hypertext links that provide an effective linkage to each agency's rules and proposed rules, and (2) the LG's website and/or the webpage containing each agency's rules and proposed rules has instructions on how to download the rules and proposed rules."

The Department satisfied section 91-2.6, HRS, because the LG's website provided a hypertext link to the Department's website, which contained the full text of the proposed administrative rules.

Section VI. RECOMMENDATIONS

The three sets of proposed administrative rules generated several testimonies in support and in opposition. Eighty-three people attended the public hearing held on February 7, 2005. Out of these eighty-three people, thirty-eight provided oral testimony. A total of 228 written testimonies were received by the Department. The majority of the testifiers were vocational rehabilitation counselors, and their clients in the workers' compensation system, the majority of whom signed form letters in objection to the proposed rules relating to vocational rehabilitation.

Testimonies from employers, medical doctors, and insurance carriers generally supported the three sets of proposals while testimonies from labor unions and claimant attorneys generally opposed portions of the three sets of proposals.

A. Summary of Testimonies, Chapter 12-10, Hawaii Administrative Rules, Relating to Workers' Compensation

The proposed rule changes in Chapter 12-10, relating to Workers' Compensation, simplify and clarify the workers' compensation claims hearings and resolution process. These rules are intended to:

- Provide for faster resolution of claims which will reduce workers' compensation costs, encourage employees to return to work in a timelier manner, and lower insurance premiums for employers.

- Ensure injured workers, suffering from economic hardship as a result of a work injury, an expedited hearing whenever a claim is denied, or whenever the employer or insurance carrier fails to respond to a hearings application.

- Improve the efficiency of the hearings process, clarifying the process, and bringing predictability, transparency and accountability in the hearings system.

- Maintain the informality of the current hearings process while ensuring fair and balanced decision making.

- Allow alternative resolution methods to resolve disputes.

- Establish clear employer self-insurance standards which enable financially solvent employers who have the ability to pay for workers' compensation benefits to take advantage of this cost saving option.

- Clarify what constitutes "disciplinary action", codifying definitions used in case law.

1. Section 12-10-1 Definitions

a. "Able to resume work"

- Proposed Rule

  Amend "Able to resume work" by deleting the reference to “temporary total disability benefits shall not be discontinued based solely on the injured worker’s inability to perform light work.” The current definition states that if an injured employee is unable to perform offered light work, temporary total disability benefits shall not be stopped based solely on this inability to perform light duty work. The justification of the proposed rule is to remove superfluous language that detracts from the intent of the definition.

- Analysis of Public Comments

  This proposed rule received forty-six testimonies in general support of the proposed amendment and thirty-four testimonies in general opposition. Only two of the testimonies in opposition objected to this specific rule change, claiming the amended definition was too vague and ambiguous and did not clearly define what would happen to the injured worker’s wage loss benefits if there is no light duty available or offered to the injured worker.

  These concerns and comments were considered in the final rule language.

- Authority to Promulgate Rule

  HRS §386-72 (Imp: HRS §386-31)

- Department’s Recommendation

  The amendment is adopted as proposed. Currently, if the injured worker is released to light duty and if there is no light duty work available and offered to the claimant, temporary total disability ("TTD") benefits should continue until the injured worker is stable and/or released to regular duty. The proposed amendment to the definition of "able to resume work" does not terminate TTD because of claimant’s inability to do light work.

b. "Attending physician"

- Proposed Rule

  Modify "Attending physician" to include the definition of physician, as defined in section 386-1, as the person who is primarily responsible for the treatment and direction of care of a work injury. The current definition of attending physician does not make reference to the definition of "physician" in section 386-1 and does not specify that the attending physician should be

responsible for the direction of care of a work injury. The justification for this proposed rule is to insure that any attending physician be a physician as defined in section 386-1 and be primarily responsible for the direction of care for the injured worker.

- Analysis of Public Comments

  There was no specific testimony commenting on the proposed definition of "attending physician". However, the proposed rule received forty-six testimonies in general support of the proposed amendment and thirty-four testimonies in general opposition.

  These concerns and comments were considered in the final rule language.

- Authority to Promulgate Rules

  HRS §§386-27, 386-72. (Imp: HRS §§386-1, 386-21, 386-25, 386-27)

- Department's Recommendation

  The amendment is adopted as proposed. The proposed definition of "attending physician" clarifies that any attending physician be a physician as defined in section 386-1 and be responsible for the direction of care for the injured worker. No specific objections to the proposed definition were presented.

c. "Days"

- Proposed Rule

  "Days" is added to mean calendar days, unless otherwise provided. Certain sections do not specify if working days or calendar days should be used. The justification for this proposed change is to clarify that if the statute and rules do not specify "working days", then "calendar days" should be used for all references to "days".

- Analysis of Public Comments

  There was no specific testimony commenting on the proposed definition of "days". However, the proposed rule received forty-six testimonies in general support of the proposed amendment and thirty-four testimonies in general opposition.

  These concerns and comments were considered in the final rule language.

- Authority to Promulgate Rules

  HRS §386-72 (Imp: HRS §§386-27, 386-31, 386-32, 386-91)

- Department's Recommendation

  The amendment is adopted as proposed. The terms "calendar days" and "working days" appear only in a few sections of the workers' compensation statute and rules. However, the term "days" appear in various sections without specifying calendar or working days. Appeals and filings predominantly follow calendar days; therefore, the Department believes calendar days are preferable.

d. "Disciplinary action"

- Proposed Rule

  "Disciplinary action" is defined as any action taken in good faith by the employer relating to or used for discipline. Disciplinary action shall include the actual sanction imposed upon a claimant for the purpose of discipline, as well as any action taken in good faith by an employer that is a part of the disciplinary process, even if no sanction or punishment is ultimately imposed. The justification for this proposed rule is to clarify disciplinary action as used in section 386-3.

- Analysis of Public Comments

  This proposed rule received forty-six testimonies in general support of the proposed amendment and thirty-four testimonies in general opposition. Only four of the testimonies in opposition objected to this specific rule change, claiming the amended rule was overly broad and overstepped the bounds of regulatory authority.

  These concerns and comments were considered in the final rule language.

- Authority to Promulgate Rules

  HRS §386-72 (Imp: HRS §386-3)

- Department's Recommendation

  In 1998, the legislature amended HRS §386-3 by adding subsection (c), which provides in relevant part that "a claim for mental stress resulting solely from disciplinary action taken in good faith by the employer shall not be allowed." "Disciplinary action" as used in HRS §386-3(c) is not currently defined, which has led to confusion as to what constitutes "disciplinary action." This

amendment provides employees, employers, and hearings officers clear rules defining "disciplinary action".

This rule also codifies the Director's and the Labor and Industrial Relations Appeals Board's ("LIRAB") rulings that any stress claim arising out of an action rendered as part of the disciplinary process is not compensable, regardless of whether or not an actual sanction or punishment was meted.

For example, in Lloyd v. Mauna Lani, Case No. 9-02-00390 (Sept 2004), the LIRAB held that "[t]he plain language of HRS §386-3(c) does not restrict 'disciplinary action' to the actual sanction or discipline meted out by an employer, and the term is not defined in Chapter 386. The legislative history of the 1998 amendment also gives no indication that the legislature contemplated 'disciplinary action' to refer only to the actual sanction imposed on an employee." The LIRAB added, "Because a sanction against an employee is often the culmination of a process undertaken by an employer to determine if the sanction is warranted, we believe that HRS §386-3(c) should be interpreted to exclude claims for stress arising out of disciplinary actions that are inclusive of the process to discipline."

Black's Law Dictionary (fifth edition) defines "discipline" as "Instruction, comprehending the communication of knowledge and training to observe and act in accordance with rules and orders. Correction, chastisement, punishment, penalty, rules and regulations."

The proposed amendment to define "disciplinary action" is not inconsistent with section 386-3, HRS.

The amendment is adopted as proposed.

e. "Good Cause"

- Proposed Rule

  Include definition of "Good cause" to mean a compelling reason for failing to perform an act required by law, unless otherwise provided. The justification for this amendment is to clarify good cause as used in the statute and administrative rules.

- Analysis of Public Comments

  There was no specific testimony commenting on the proposed definition of "Good cause". However, the proposed administrative rules received forty-six testifiers in general support of the proposed amendment and thirty-four testifiers in general opposition.

  These concerns and comments were considered in the final rule language.

- Authority to Promulgate Rules

  HRS §386-72.

- Department's Recommendation

  The amendment is adopted as proposed. The amendment provides "notice" to parties (claimants, employers, providers, and attorneys) that a finding of good cause will be based upon the circumstances in each case. No specific objections were presented against the proposed definition.

2. Section 12-10-21 Disabilities

- Proposed Rule

  "Disabilities" is amended by requiring the attending physician to certify that the injured employee was not able to complete the employee's work shift on the date of injury. Currently, if the injured employee is unable to complete their work shift on the date of injury, this date of injury is considered the first day of disability and is counted as the first day of the waiting period. The justification for this change is to require proof of disability that the injured employee was unable to complete the employee's work shift on the date of injury.

- Analysis of Public Comments

  This proposed rule received forty-six testimonies in general support of the proposed amendment and thirty-four testimonies in general opposition. Only three of the testimonies in opposition objected to this specific rule change, claiming the amendment would be an imposition to the physician to write retroactive certification of disability if the injured employee could not see the physician on the date of injury. They also claimed that there would be an imposition placed upon the claimant to always go to the physician to obtain disability certification and the confusion it would place upon an injured claimant as to the first day the waiting period would begin.

  These concerns and comments were considered in the final rule language.

- Authority to Promulgate Rule

  HRS §386-72 (Imp: HRS §§386-31, 386-32, 386-33, 386-34)

- Department's Recommendation

  Based on testimonies received, this amendment is withdrawn.

3. Section 12-10-65 Discovery

- Proposed Rule

  The section entitled "Depositions" is amended by renaming this section "Discovery" and adding new rules and procedures for the process of discovery in workers' compensation cases. Currently, there are no rules relating to the discovery process as a whole, although the parties have conducted discovery relying on "unwritten rules" or "past practices". The justification for this section is to provide clear notice of rules and procedures for discovery in the workers' compensation process to promote fairness, transparency, and efficiency.

- Analysis of Public Comments

  This proposed rule received forty-six testimonies in general support of the proposed amendment and thirty-four testimonies in general opposition. Only one of the testimonies in opposition objected to this specific rule change, claiming the amendment was too formal, and would result in delays and increased litigation, as well as the Department's ability to process depositions, subpoenas, witness fees for subpoenaed witnesses, and additional discovery. Concern was also expressed as to whether or not pro se claimants would understand these more formal procedures regarding "discovery".

  These concerns and comments were considered in the final rule language.

- Authority to Promulgate Rule

  HRS §386-72 (Imp: HRS §386-86)

- Department's Recommendation

  The Department believes that the hearings process should be predictable, transparent and accountable. This is especially imperative to pro se claimants who are expected to defend themselves in a system that currently offers no guidelines or instruction on what is expected of them during the hearings process. The Department is not imposing new requirements or formalizing the hearings process. Discovery such as depositions and interrogatories are already used by attorneys in the workers' compensation system, as noted by some of the testifiers, including an experienced claimant attorney. Setting forth clear rules and/or codifying the current process provides sufficient notice to the parties on the "Discovery" process, promoting transparency, accountability, efficiency, and leveling the playing field. It is in this spirit that these rules regarding "discovery" are being proposed.

  The current system of "unwritten rules" provides an unfair disadvantage to "pro se" claimants or inexperienced employer representatives and attorneys. The current system only benefits those who have practiced in the system for years.

The amendment is adopted as proposed.

4. Section 12-10-66 Alternative resolution

- Proposed Rule

  "Subpoenas" is amended by deleting the current rules relating to subpoenas and inserting the subpoena rules in section 12-10-65 under "Discovery". This section will be renamed "Dispute Facilitation and Mediation" and will include new rules and procedures relating to the alternative dispute resolution and mediation process in the workers' compensation system. Although allowed under the current system, there are no administrative rules governing alternative dispute resolution in the workers' compensation system. These rules clarify how dispute resolution and mediation may be used to resolve dispute or claims in the workers' compensation system.

- Analysis of Public Comments

  This proposed rule received forty-six testimonies in general support of the proposed amendment and thirty-four testimonies in general opposition. Only four of the testimonies in opposition objected to this specific rule change, claiming the amendment was overly cumbersome and that the injured employee should not be required to split the cost of a referee or mediator. It also noted that the referees should meet some minimum qualifications before presiding over a hearing.

  These concerns and comments were considered in the final rule language.

- Authority to Promulgate Rule

  HRS §386-72 (Imp.: HRS §386-86)

- Department's Recommendations

  The Department, for many years, has allowed litigants to resolve their workers' compensation dispute through alternative dispute resolution process, although there are currently no written rules governing the process. The Department believes that the process should be set forth in rules to provide clear direction on how the process works. Furthermore, this will encourage the parties to consider alternative dispute resolution methods in resolving workers' compensation claims as they provide an effective option in resolving disputes in a timely and more efficient matter.

  The rules specify that both the claimant and the employer must both agree to enter into an alternative dispute resolution to have the case resolved by a private referee or mediator. They must both agree to the referee and his or her qualifications and may agree to shift the cost of the fees for the proceedings to either party if both

parties agree to such an arrangement. In cases where it would be beneficial for the employer to pay for the entire cost of the alternative dispute resolution process, the employer may do so under these rules.

The amendment is adopted as proposed.

5. Section 12-10-67 Witness Fees

- Proposed Rule

"Witness fees" is repealed. These rules will be included in the "Discovery" section under §12-10-65 to consolidate all rules relating to the "Discovery" process.

- Analysis of Public Comments

There was no specific testimony commenting on the proposed rule regarding "witness fees". However, the proposed rule received forty-six testimonies in general support of the proposed amendment and thirty-four testimonies in general opposition.

These concerns and comments were considered in the final rule language.

- Authority to Promulgate Rule

HRS §386-72 (Imp: HRS §91-2)

- Department's Recommendation

The amendment is adopted as proposed.

6. Section 12-10-69 Attorney's fees

- Proposed Rule

Section 12-10-69, "Attorney's fees", is amended by clarifying factors which the director should consider in determining an attorney's approved hourly rate and the number of hours allowable in approving their Requests for Approval of Attorney's Fees. The amendment also caps the maximum allowable attorney's fees to be no greater than 15% of the benefits awarded to claimants to ensure that not all of the claimant's award will be depleted by attorney's fees. The justification for this amendment is to provide objective standards in determining the amount attorneys representing claimants should be compensated. The current process of establishing attorney's fees does not present clear objective guidelines for setting appropriate fees for attorneys.

- Analysis of Public Comments

  This proposed rule received forty-six testimonies in general support of the proposed amendment and thirty-four testimonies in general opposition. Only five of the testimonies in opposition objected to this specific rule change, claiming the 15% cap on attorney fees would be unfair to attorneys where the claimant received little to no award, or if the attorney fails to prove his clients claim is compensable.

  These concerns and comments were considered in the final rule language.

- Authority to Promulgate Rule

  HRS §386-72 (Imp: HRS §386-94)

- Department's Recommendation

  The Department's current method for determining attorney's fees provides the appearance of impropriety and has yielded many complaints from claimant attorneys regarding how their fee is determined. The Department believes that it is important to clarify attorney's fee approval criteria to remove any appearance of impropriety. However, based on the testimony opposing the 15% cap on attorneys' fees, that specific provision is withdrawn.

7. Section 12-10-72.1 Hearings Process

- Proposed Rule

  A new section is proposed to describe and clarify the hearings process to include such items as requests for hearings, response to application for hearing, evidence at hearings, witnesses at hearings, continuance of hearings, and submission of reports.

  There are currently no administrative rules governing the hearings process. This has made the hearings process unpredictable, provides an appearance of favoritism with regard to calendaring of hearings, and inefficiency in resolving claims in a timely manner. This section also clarifies the powers and duties of the hearings officer and requires that all hearings will be electronically recorded.

  The proposal requires hearings to be held within 60 days after a response to an application for a hearing has been filed. Currently, there are no rules specifying when a hearing should be held, often causing injured workers to suffer economic hardship while they wait for their "day in court."

  Further, the injured worker, suffering from economic hardship, will be entitled to an expedited hearing if the employer or its insurance carrier fails to respond to the application for a hearing. Currently, there are no rules that provide injured

workers the right to have an expedited hearing. This proposal also provides that if there are no material facts in dispute, decisions may be rendered based on the records without a hearing. This hearings process is intended to be transparent and provide all parties with a clear understanding of the process and timetables.

- Analysis of Public Comments

  This proposed rule received forty-six testimonies in general support of the proposed amendment and thirty-four testimonies in general opposition. Only six of the testimonies in opposition objected to this specific rule change, claiming the amended definition was too formal and would result in delays and increased litigation, concerns were also raised about the Department's ability to process depositions, subpoenas, witness fees for subpoenaed witnesses, and additional discovery. Additionally, there were questions as to whether or not pro se claimants would understand these more formal procedures.

  These concerns and comments were considered in the final rule language.

- Authority to Promulgate Rule

  HRS §386-72 (Imp: HRS §386-86)

- Department's Recommendation

  The Department believes that these basic hearings rules modernize the hearings process, bringing predictability, transparency, and accountability in a hearings system that is plagued with complaints of inefficiency, irregularities and soaring costs. Currently, there are no administrative rules governing the hearings process. This has led to a process that is unpredictable and gives the appearance of favoritism with regard to calendaring and conducting hearings.

  Under the current system which has no rules, injured employees, representing themselves (without an attorney – pro se) are at a tremendous disadvantage as the system fails to provide them proper notice of their rights regarding the hearings process.

  The proposed amendment will ensure that the injured worker will have his or her "day in court" in a timely manner. *There is no such procedure under the current rules.* Additionally, the requirement to have all hearings be recorded would allow the Department to periodically review the recordings to ensure that the parties receive a fair and impartial hearing, and to ensure that there is consistency in the Department’s decisions.

  The Department believes that the interest of keeping the hearings process lax and "informal" must be balanced with keeping the process fair, balanced and efficient. These proposed rules strike the balance of maintaining a transparent, fair and

equitable hearings process while maintaining its informality. It is in this spirit that the amendments are proposed.

The amendment is adopted as proposed.

8. Section 12-10-94 Self-insurance; application; duration; cancellation; revocation

- Proposed Rule

  This section is amended to clarify and provide a more detailed description of the process and requirements for qualifying and obtaining the Department's approval to be a self insured employer. This will assist employers who are contemplating whether or not they qualify for workers' compensation self-insurance and to provide objective guidelines to apply for self-insurance.

- Analysis of Public Comments

  There was no specific testimony commenting on the proposed rule regarding "Self-insurance; application; duration; cancellation; revocation". This proposed rule received forty-six testimonies in general support of the proposed amendment and thirty-four testimonies in general opposition.

  These comments were considered in the final rule language.

- Authority to Promulgate Rule

  HRS §386-72 (Imp: HRS §386-121)

- Department's Recommendation

  The amendment is adopted as proposed.

B. Summary of Testimonies, Chapter 12-15, Hawaii Administrative Rules, Relating to Workers' Compensation Medical Fee Schedule

The proposed rule changes to Chapter 12-15, relating to Workers' Compensation Medical Fee Schedule, establishes procedures to simplify and clarify the applicable rules. These amendments will ensure injured workers receive reasonable and necessary quality care based upon evidence-based medicine. Specifically, these rules will:

- Enable provisions of evidence-based medical treatment based upon guidelines of the American College and Occupational and Environmental Medicine and the Official Disability Guidelines ("ODG") published by the Work Loss Institute.

- Allow medical providers flexibility to treat an injured worker more extensively than what guidelines may prescribe, provided that there is a necessity and is supported by evidence-based medicine.

- Reduce delays resulting from unnecessary disputes and litigation over treatment plans.

1. Section 12-15-1 Definitions

a. "Emergency medical services"

- Proposed Rule

  Define "Emergency medical services" to mean initiating all basic life support care to stabilize and support a patient's condition due to sudden illness or injury within the first seventy-two hours after date of injury. This rule will allow medical providers to deviate from the treatment guidelines as referenced in section 12-15-32 and emergency medical treatment in section 12-15-50, during an emergency situation during the first seventy-two hours.

- Analysis of Public Comments

  This proposed rule received forty-six testimonies in general support of the proposed amendment and thirty-four testimonies in general opposition. Only two of the testimonies in opposition objected to this specific rule change, claiming that medical providers should be allowed to deviate from the medical guideline in an emergency situation, regardless of whether it occurs during or after the first seventy-two hours from pint of injury.

  These concerns and comments were considered in the final rule language.

- Authority to Promulgate Rules

  HRS §386-72 (Imp: HRS §386-21)

- Department's Recommendation

  Based upon testimonies received the Department withdraws this proposed definition. The Department will also withdraw its amendment to section 12-15-50, which initially proposed that emergency medical treatment is performed immediately or within the first seventy-two hours from the end of the work day shift on date of injury. Currently, emergency treatment includes treatment within fourteen calendar days of the injury.

b. "Evidence based"

- Justification of Proposed Rule

  Define "Evidence based" to mean the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual injured employees entitled to benefits. This is to ensure that treatment plans

submitted by health care providers are supported by scientific medical evidence to ensure that the injured employee is properly cared for. This is to clarify treatment guidelines as referenced in section 12-15-32.

- Analysis of Public Comments

  This proposed rule received forty-six testimonies in general support of the proposed amendment and thirty-four testimonies in general opposition. Only two of the testimonies in opposition objected to this specific definition, claiming the amendment, in combination with proposed amendments to section 12-15-30, would force a "cookie cutter" approach to medicine for physicians, chiropractors, massage therapists, and other health care providers. They claim it would preclude the use of their expertise and institutional knowledge, preclude occupational services, and is contrary to section 386-26, HRS.

  These comments were considered in the final rule language.

- Authority to Promulgate Rules

  HRS §386-72 (Imp: HRS §§386-21, 386-26, 386-72)

- Department's Recommendation

  The Department believes that medical providers should use the most current best evidence in making decisions about the care of individual injured employees. This will ensure that injured employees receive the best care possible and are not unduly delayed in their recovery and return to the workforce in the most efficient manner possible. It will also reduce the financial burden on an employee and their families due to a prolonged absence from work.

  The amendment is adopted as proposed.

2. Section 12-15-30 Provider of Service Responsibilities

- Proposed Rule

  This section is amended to clarify that the treatment guidelines as specified in the rules are guidelines to improve provider of service accountability and are a presumptive, not authoritative, prescription for health care. Providers of service shall follow the rules as specified in the amended section 12-15-32. The justification for this amendment is to clarify that providers of service shall follow the treatment guidelines in section 12-15-32.

- Analysis of Public Comments

  This proposed rule received forty-six testimonies in general support of the proposed amendment and thirty-four testimonies in general opposition. Only three of the testimonies in opposition objected to this specific rule change, claiming the amendment would force a "cookie cutter" approach to medicine for physicians, chiropractors, massage therapists, and other health care providers. They claim it would preclude their expertise and institutional knowledge, preclude occupational services, and is contrary to section 386-26, HRS. The testimony in opposition also claimed that the amendment making the treatment guidelines established in section 12-15-32 "presumptive", was contrary to the intent of section 386-21, HRS.

  These comments were considered in the final rule language.

- Authority to Promulgate Rules

  Auth: HRS §§386-26, 386-27, 386-72 (Imp: HRS §§386-21, 386-26, 386-27, 386-94, 386-96)

- Department's Recommendation

  Act 260 of 1996 Session Laws of Hawaii (amendments to section 386-26) mandates the Director of Labor and Industrial Relations to formulate and implement treatment and utilization guidelines. The Department has not fulfilled its obligation specified in Act 160 enacted nine years ago. Previous administrations have failed to fulfill this mandate, as they adopted cursory guidelines that are not based on any medical evidence.

  Concerns were also raised that this rule would eliminate the health care providers from using their discretion and implement a "cookie-cutter" approach to medicine. The Department agrees that physician discretion is necessary, but that for many diagnoses the treatment steps should conform to practices that objectively seem to have the best chance of producing the best outcomes. Physicians should be provided flexibility to treat more aggressively and extensively than what the treatment guidelines specified in section 12-15- 32, provided there is an objective medical justification and ongoing monitoring of the patient's response to treatment.

  Injured workers must be assured that they are receiving medical treatment based on the best practices of medicine, so that they can return to the workforce in the most efficient manner possible so that they and their families are not hurt financially by a prolonged absence from work.

  The amendment is adopted as proposed.

3. Section 12-15-31 Who may provide services

- Proposed Rule

  This section is amended to clarify that all treatment and prescriptions shall be in writing and in accordance with sections 12-15-30 and 12-15-32 relating to providers of service and their responsibilities.

- Analysis of Public Comments
  There was no specific testimony commenting on this specific section. This proposed rule received forty-six testimonies in general support of the proposed amendment and thirty-four testimonies in general opposition.

  These comments were considered in the final rule language.

- Authority to Promulgate Rules

  Auth: HRS §§386-21, 386-26, 386-27, 386-72 (Imp: HRS §§386-21, 386-26, 386-27)

- Department's Recommendation

  The amendment is adopted as proposed.

4. Section 12-15-32 Physicians

- Proposed Rule

  This section is amended and renamed "Providers of Service" to combine sections 12-15-32 and 12-15-34 to provide frequency of treatment guidelines for all providers of service. This amendment requires that the Official Disability Guidelines Treatment in Workers' Comp, 3rd edition, (hereafter "ODG") issued by the Work Loss Data Institute and the treatment guidelines, chapters 1-7, issued by the American College of Occupational and Environmental Medicine, 2nd Edition, shall be presumptive.

  For all injuries not covered by the ODG Treatment in Workers' Comp, 3rd edition, treatment shall be in accordance with evidence based medical treatment guidelines. The attending physician shall submit a "Restorative Services Plan" on a form prescribed by the Department. If the attending physician believes additional treatment is required, the attending physician shall mail a treatment plan to the employer at least fourteen calendar days prior to the start of the additional treatments. With the exception of emergency medical services, any provider of service who exceeds the treatment guidelines without proper authorization shall be denied compensation for the unauthorized services.

Currently, frequency of treatment guidelines for physicians is listed in section 12-15-32 and frequency of treatment guidelines for providers of service other than physicians are listed in section 12-15-34. This amendment will combine both sections for clarity and consistency in treatment guidelines for all providers of service. The justification for this amendment is to establish uniform treatment guidelines for all providers of service to treat injured workers. This will ensure consistency in treatment and medical billing for similar types of injuries from all providers of service.

Since 1995, Hawaii has seen an increase in the amount of time it takes to return injured workers back to the workforce. This has unnecessarily increased costs the system. This amendment will ensure that Hawaii's injured workers will receive quality medical care. Treatment guidelines will also ensure that treatment is not over utilized and that the injured worker will be able to return to work in an appropriate timeframe, thereby reducing any economic burden caused by the delay in treatment and care.

- Analysis of Public Comments

  This proposed rule received forty-six testimonies in general support of the proposed amendment and thirty-four testimonies in general opposition. Only sixteen of the testimonies in opposition objected to this specific rule change, claiming that the imposition of medical treatment guidelines would result in increased medical costs and premiums. Additionally, concerns were raised that the amendment would force a "cookie cutter" approach to medicine for physicians precluding use the use of their expertise and institutional knowledge.

  These comments were considered in the final rule language.

- Authority to Promulgate Rules

  Auth: HRS §§386-21, 386-26, 386-72 (Imp: HRS §§386-21, 386-26, 386-27)

- Department's Recommendation

  In response to concerns that costs would be increased with the enactment of this provision, the Department references a University of California – Berkeley study conducted by Professor Frank Neuhauser that found that the implementation of medical treatment guidelines would save California's workers' compensation system 36.7%. While recognizing that there are differences between Hawaii's workers' compensation system and California's, Hawaii has the potential to save $98 million in annual savings due to the implementation of these treatment guidelines.

  Act 260 of 1996 Session Laws of Hawaii (amendments to section 386-26) mandates the Director of Labor and Industrial Relations to formulate and implement treatment and utilization guidelines. The Department has not fulfilled

its obligation specified in Act 160 enacted nine years ago. Previous administrations have failed to fulfill this mandate, as they adopted cursory guidelines that are and not based on any medical evidence. This proposed rule fulfills this legislative mandate.

Concerns were raised that this rule would eliminate the health care providers from using their discretion and implement a "cookie-cutter" approach to medicine. The Department agrees that physician discretion and flexibility is necessary, but that for many diagnoses the treatment steps should conform to practices that objectively seem to have the best chance of producing the greatest outcomes. Physicians should be provided flexibility to treat more aggressively and extensively than what the treatment guidelines allow, supported by evidence-based medicine, provided there is an objective medical justification and ongoing monitoring of the patient's response to treatment.

The rationale for the implementation of treatment guidelines come from three basic problems found in Hawaii's workers' compensation system:

a. Treatment patterns are all over the spectrum for common injuries.
b. Higher indemnity and medical costs are associated with the unmanaged practice of medicine.
c. Higher friction costs, (i.e., overcoming obstacles to resolve claims in a timely manner) are associated with deviations from rendering treatments in accordance with the best practices of medicine.

The treatment guidelines the Department is proposing is designed to curtail the effects of bias in formulating a treatment plan and the friction that becomes associated with that plan once the employer/carrier begins the dispute process.

National studies performed by physician organizations and accredited universities show that medical treatment guidelines can effectively educate system participants about new treatments and positive treatment outcomes. They can also improve consistency in the medical care provided to injured workers and control the over-utilization of medical care.

These same studies, such as those produced by the RAND Corporation, have noted that medical treatment guidelines play an important role in facilitating evidence-based clinical decision making, and strengthening efforts to evaluate practitioner and health system performance. Treatment guidelines have many uses, the most important of which is to extract research evidence into a more usable form for physicians already overburdened with paperwork and non-workers' compensation injuries and illnesses. These treatment guidelines are developed to increase the quality and consistency of the care provided to injured workers for their specific condition.

The amendment is adopted as proposed.

5. Section 12-15-34 Providers of Service other than Physicians

- Proposed Rule

  This section is repealed. Frequency of treatment guidelines for all providers of service will be listed in section 12-15-32 for consistency and clarification.

- Analysis of Public Comments

  There was no specific testimony commenting on this specific section. This proposed rule received forty-six testimonies in general support of the proposed amendment and thirty-four testimonies in general opposition.

  These comments were considered in the final rule language.

- Authority to Promulgate Rules

  HRS §386-72 (Imp: HRS §386-21)

- Department's Recommendation

  The amendment is adopted as proposed.

6. Section 12-15-50 Emergency Treatment

- Proposed Rule

  Amend subsection (c), "Emergency treatment" to clarify that the emergency treatment is considered to be treatment for a life-threatening condition which must be performed immediately or within seventy-two hours from the end of the workday shift on date of injury. Currently, emergency treatment includes treatment within fourteen calendar days of the injury. Since emergency care is most crucial in the initial seventy-two hours after the accident, the time period for emergency treatment is shortened to reflect this seventy-two hour period.

- Analysis of Public Comments

  This proposed rule received forty-six testimonies in general support of the proposed amendment and thirty-four testimonies in general opposition. Only two of the testimonies in opposition objected to this specific rule change, claiming that medical providers should be allowed to deviate from the medical guideline in an emergency situation, regardless of whether it occurs during or after the first seventy-two hours from point of injury.

  These concerns and comments were considered in the final rule language.

- Authority to Promulgate Rules

HRS §386-72 (Imp: HRS §386-21)

- Department's Recommendation

  Based on testimonies received, this amendment is withdrawn.

7. Section 12-15-85 Rules for allowable fees for medical, surgical, and hospital services and supplies

   - Proposed Rule

     Amend subsection (h), "Rules for allowable fees for medical, surgical, and hospital services and supplies" to clarify what the providers of service must include in their billing statements to certify that the charges are for treatment of a work injury or illness. This is to verify that the provider is treating a work injury and billing in accordance with the workers' compensation law and related rules.

   - Analysis of Public Comments

     There was no specific testimony commenting on this specific section. This proposed rule received forty-six testimonies in general support of the proposed amendment and thirty-four testimonies in general opposition.

     These comments were considered in the final rule language.

   - Authority to Promulgate Rules

     HRS §§386-72, 386-21 (Imp: HRS §386-21)

   - Department's Recommendation

     The amendment is adopted as proposed. The current rule only specifies that each provider certify, on the bills or charges, that such charges are in accordance with chapter 386, HRS. This proposal specifies criteria for certifying bills. No specific objections to this proposal were presented.

8. Section 12-15-94 Payment by employer

   - Proposed Rule

     "Payment by employer" is amended by penalizing the providers of service one dollar per charge that is billed incorrectly. Currently, if the charges are billed in excess of Medicare plus ten percent, or in excess of Exhibit A of the Workers' Compensation Medical Fee Schedule, the insurance adjustors may adjust the charge to the maximum allowable charges under the Workers' Compensation

Medical Fee Schedule. This amendment is to require the providers of service to comply with the Workers' Compensation Medical Fee Schedule.

- Analysis of Public Comments

  This proposed rule received forty-six testimonies in general support of the proposed amendment and thirty-four testimonies in general opposition. Only three of the testimonies in opposition objected to this specific rule change, claiming the amendment could increase administrative expenses for providers and continue to dissuade providers from accepting workers' compensation cases.

  These comments were considered in the final rule language.

- Authority to Promulgate Rules

  HRS §386-72 (Imp: HRS §386-21)

- Department's Recommendation

  Based on testimonies received, this amendment is withdrawn. The current rule specifies that each provider certify on the bill or charges, that such charges are in accordance with Chapter 386, HRS. Employers are allowed to withhold payment to health care provider fees for failure to comply with Chapter 386 and related rules. Furthermore, section 12-15-94 allows the employers to challenge a health care provider billing.

C. Summary of Testimonies, Chapter 12-14, Hawaii Administrative Rules, Relating to Vocational Rehabilitation

The proposed rule changes to Chapter 12-14, relating to vocational rehabilitation under workers' compensation pursuant to section 386-25, HRS, sought to establish procedures to simplify and clarify the rules relating to vocational rehabilitation. These amendments were intended to:

- Ensure injured workers receive necessary vocational rehabilitation services in the most cost-effective and efficient manner.

- Encourage the employee, medical provider, vocational counselor and the employer to work cooperatively in designing and monitoring the employee's vocational rehabilitation program.

- Expedite the approval of vocational rehabilitation plans.

- Encourage employers to provide an effective back-to-work program so that employees can return to work at their wages before the injury.

- Initially limit vocational rehabilitation plans to 104 weeks unless circumstances warrant a revision or extension beyond 104 weeks.

- Restore an injured worker's earnings capacity, as nearly as possible, to the level which the worker was earning at the time of injury, and to return the injured worker to suitable work in the active labor force as quickly as possible in a cost-effective manner.

These proposed rules received forty-six testimonies in general support of the proposed amendments and one hundred and thirty-one testimonies in general opposition. Vocational rehabilitation counselors, claimant attorneys, and claimants submitted the majority of the testimonies opposing the proposed rules. Most of the written opposition was submitted by way of form letters faxed from the individual vocational rehabilitation clinics. Most of the testimonies in favor of the proposed rules were submitted by employers, small business owners, and business organizations.

Due to the number of testimonies and numerous concerns raised, the Department will defer on these rules. The Department will work with the various stakeholders to discuss the concerns and differences of opinions submitted at the hearing and develop revised administrative rules for public hearing to be scheduled in late 2005.

Appendices

Appendix I

FULL LEGISLATIVE HISTORY OF WORKERS' COMPENSATION

The Original Act of 1915 (Session Laws of Hawaii 1915, Act 221)

The Hawaii Territorial Legislature adopted the State's first Workers' Compensation Law in 1915. The Workers' Compensation Law was enacted to ensure that employees who were injured or disabled on the job were provided with medical treatment and fixed monetary awards (indemnity). This law was Hawaii's first "no-fault" legislation in that it mandated there be a presumption that an employee's injuries were "work-related", while prohibiting an employee from filing civil actions against the employer for work-related injuries or illnesses.

The Act covered personal injury by accident arising out of and in the course of covered employment, including injury caused by the willful act of a third person directed against an employee because of their employment. The Act excluded injury caused by the employee's willful intention to injure themselves or another person or by their intoxication. Death resulting from injury within six months was covered.

Under the current law, an employee sustaining a work-related injury or illness is entitled to medical treatment, wage loss benefits, permanent disability indemnity, disfigurement and death benefits. Any employer, including the State and County governments, employing one or more workers is required to provide workers' compensation coverage.

1917 Amendments (Session Laws of Hawaii 1917, Act 227)

These amendments dealt with provisions governing coverage, computation, and measure of benefits, and procedure and security of payment. The former brief schedule of benefits for specified permanent partial disability was replaced by a much larger list of scheduled disability benefits. The previous $12 ceiling on benefits was dropped and was fixed at 50% of the average weekly wage for a specified varying number of weeks.

1923 Amendments (Session Laws of Hawaii 1923, Act 37 and Act 249)

Monetary limits on medical benefits were eliminated and it was specified that amounts of scheduled injuries (specific injuries that are listed in the statute) were in addition to the compensation for medical expenses. The floor and ceiling on total disability benefits were raised from $3 and $18 to $5 and $20, respectively, with the exception that in cases of temporary total disability, benefits should not exceed the actual average weekly wage.

The catalogue of scheduled injuries was further extended to cover all permanent injuries to the listed members or components of members regardless of their loss of earning capacity. The amendment restored the aggregate limit of $5,000 on the entire indemnity benefits for total and partial disability resulting from injury. Additionally, the schedule was again extended to cover injuries to multiple toes or fingers.

1927 Amendments (Session Laws of Hawaii 1927, Act 207)

In 1927, a general floor of $5 on weekly benefits for permanent partial disability of minors was added.

1937 Amendments (Session Laws of Hawaii 1937, Act 66 and Act 237)

In 1937, the Legislature introduced and adopted Act 66 to facilitate the employment of handicapped workers. If an employee who had previously incurred a permanent total disability through the loss of a hand or foot sustained a compensable accident resulting in the loss of another hand or foot, or if having lost sight in one eye, they lost sight in the other, the employer or their insurer was liable only for compensation of the permanent partial disability caused by the subsequent injury. The employee retained entitlement to benefits for total permanent disability, but the remaining balance was to be paid out of a **newly created special compensation fund** collected from payments imposed in death cases where the deceased employee left no dependents.

Additionally, Act 237, to become effective on January 1, 1940, reorganized the administration of the Workers' Compensation Act while also **creating the Department of Labor and Industrial Relations**. The chief administrative officer of the Department was designated as the Director of Labor and Industrial Relations. The Act placed the Bureau of Workmen's Compensation under the immediate supervision of an Assistant Director. An appeals board for each of the counties was also established. The Director was authorized to exercise original jurisdiction over all compensation cases by assuming the powers formally vested in the Industrial Accidents Boards. Appeals from the decisions of the Director were provided either to the Labor and Industrial Appeals Board for cases from the City and County of Honolulu, or to one of the three Industrial Accident Boards for cases arising in the other respective counties. A further appeal with a right-to-jury trial was likewise provided, with jurisdiction lying with the appropriate circuit court.

1939 Amendments (Session Laws of Hawaii 1939, Act 206)

The end of the depression period in 1939 brought a major revision to the benefits formula and earning limits of covered employees. The new statute significantly differentiated the cases of permanent total disability, temporary total disability, permanent partial disability, and temporary partial disability. Benefits for permanent total disability were fixed at 60% of the average weekly wage with a minimum of $5 and a maximum of $25, subject to a time limit of 312 weeks and an aggregate ceiling of $5,000.

Benefits for temporary total disability were to be paid on the same scale, but workers with average weekly earnings of less than $5 were only to receive the full amount of their average weekly wage. Maximum duration of benefits was fixed at 312 weeks and the maximum aggregate amount at $5,000. There was a waiting period of seven days for temporary total disability of forty-nine days or less. The rate of compensation for permanent partial disability of the types enumerated in the schedule was increased to 60% of the average weekly wage.

1941 Amendments (Session Laws of Hawaii 1941, Act 253)

The Legislature expanded the coverage of death to include any death arising from within one year of the industrial accident.

1943 Amendments (Session Laws of Hawaii 1943, Act 157)

1943 saw major revisions to the rates of compensation, duration of benefits, floors and ceilings on weekly payments, and aggregate limits. The compensations were raised from 60% of the average weekly wage to 66 2/3%. This increase affected the rate of compensation for death where the deceased left a widow or widower and three or more dependent children. It also affected total disability, whether temporary or permanent, for scheduled or non-scheduled cases of permanent partial disability, and for temporary partial disability.

The amendments eliminated the 312 weeks limitation on the duration of benefits throughout the statute. However, in cases of scheduled injuries and temporary partial disability, shorter limits were inserted to counterbalance the increase in the basic rate of compensation. In the case of scheduled injuries, adjustments of duration were made throughout the schedule. The maximum duration for temporary partial disability was fixed at 260 weeks, while the aggregate limits for death benefits and the entire disability benefits in any case were raised to $7,000.

Additionally, the minimum and maximum weekly wages used in the computation for death benefits, as well as the floor and some ceilings on weekly disability benefits, were raised. The weekly earning base for death benefits ranged from $12.50 to $37.50. The existing floors for weekly benefits in cases of total disability and permanent partial disability minors were increased to $8. Maximum weekly benefits for temporary partial disability were raised to $25. Additionally, the amendment reinserted a floor of $8 and a ceiling of $25 on benefits for scheduled injuries.

Further, in conjunction with the change in benefit levels, the amendments modified the coverage provisions to include private employees whose weekly remuneration did not exceed $100 and public officials whose salaries were not more than $2,400. The limitation on the age of dependency for children was raised to 18, and burial expenses were increased to $200.

1945 Amendments (Session Laws of Hawaii 1945, Act 10)

The Legislature amended the law to allow elective coverage for private employers engaged in trade, occupation, non-profits (then called "business not for pecuniary gain"), and for employees earning more than $100 a week. Additionally, the Act provided for a monthly allowance of $50 to defray expenses for an attendant needed by a person suffering permanent total disability. Procedures were also streamlined by eliminating the report to the committee of arbitration and tightening reporting requirements.

1947 Amendments (Session Laws of Hawaii 1947, Act 64 and Act 81)

The Legislature established the Division of Industrial Safety (presently known as the Hawaii Occupational Safety and Health division ["HIOSH"]) within the Bureau of Workmen's Compensation. Authority was given to enforce safety standards, materials and equipment as necessary, were to be financed from a special fund established as The Special Compensation and Accident Prevention Fund.

1949 Amendments (Session Laws of Hawaii 1949, Act 110, Act 111, Act 131, and Act 293)

Among the numerous amendments enacted in 1949, the most significant were the requirements that there be required coverage for all employees in industrial employment regardless of their weekly wages, and for all non-elective public officials, regardless of their annual salary.

Compensability for death was expanded from within one year of the date of injury to three years. The maximum average weekly wage to be considered in the computation of death benefits was raised to $52.50 and burial expenses were covered up to $300. Additionally, non-resident alien dependents of certain categories became entitled to 50% of the regular dependents' benefits.

Further, the maximum aggregate benefit was raised to $10,500 in cases of permanent total disability, permanent partial disability, and combined disability and death benefits. The ceiling on weekly benefits in the cases of permanent or temporary total disability and permanent partial disability of a scheduled type was raised to $35. The waiting period in cases of temporary total disability was reduced to 5 days, and the period after which retroactive payments from the date of disability were required was shortened to 21 days. Also, the schedule of benefits for the loss of the first phalanx of the thumb or finger and the loss of one eye by enucleation (removal) were increased. The Legislature also revised the reporting requirements to assure more supervision for observance of the law.

The amendments of 1949 reflect the Legislature's first intent to shift the determination of disability benefits based on reduction of earning capacity to that based on loss of physical function.

1951 Amendments (Session Laws of Hawaii 1951, Act 49, Act 50, and Act 194)

The amendments of 1951 completed the shift from compensation based on reduction of earning capacity to that based on the loss of physical function in cases of permanent partial disability by radically rewording the subsection relating to non-scheduled cases. Disability determined as a percentage of permanent total disability was to be compensated as a corresponding percentage of $10,500.

Facial and head disfigurements were made compensable without requiring qualifications such as "serious" and the schedule for losses of one or more phalanges of the thumb or finger were again revised. Additionally, third party liability was added to be subjected to the Act.

The aggregate maximum of benefits for death, temporary total disability, and temporary partial disability were again raised and an aggregate maximum for the case of successive total and partial disability fixed at the same amount was reinserted. Additional benefits were provided for total disability payable after reaching the amount of $10,500. The additional benefits were imposed upon the Special Compensation and Accident Prevention Fund at a rate of 50% of the regular weekly benefit, not less than $10 per week.

1953 Amendments (Session Laws of Hawaii 1953, Act 41, Act 51, Act 98, and Act 266)

The amendments revised compensation payments for subsequent injuries to extend it to all injuries which, because of a pre-existing disability, caused permanent total disability and without such previous injury would have caused only partial disability. These new provisions were intended to enhance employment opportunities for handicapped workers. Additionally, the rate of compensation of death benefits was raised to $400 and the rate of compensation of death benefits was raised for surviving dependent spouses without dependent children, to 50%.

Further, provisions relating to notice of injury, claim for compensation, and the continuing jurisdiction of the Director were revised.

1955 Amendments (Session Laws of Hawaii 1955, Act 13, Act 14, and Act 27)

In 1955, the Legislature enacted extensive revisions to the structure of benefits and the various limitations built into the law that became effective that same year. Significant changes were made to the aggregate maximum of compensation payments payable to beneficiaries or chargeable to the employer or insurance carrier. Changes were also enacted on the ceilings and floors for weekly benefits and on the rate of compensation for death that was accorded to certain classes of dependents. Essentially, the aggregate maximum amount of benefits for any death benefits chargeable to the employer for permanent total disability, benefits for temporary total disability, and for combined total and partial disability, was raised to $20,000. Additionally, $20,000 was then used as the basis for calculating the compensation for non-scheduled permanent partial disability.

The Legislature also amended death to be compensable if it resulted from covered injury, regardless of the time elapsing between the injury and death. The Legislature also mandated that widows who did not remarry and lacked the capability of self-support would now be entitled to life pensions. Additionally, the amendments also authorized payments for rehabilitation to be paid from the Special Fund, not to exceed $1,000.

Compensation benefits as a whole saw increases under the 1955 amendments as well as the removal of specific limits on duration, except those resulting from claimants reaching the maximum aggregate amount of $20,000.

1957 Amendments (Session Laws of Hawaii 1957, Act 55, Act 78, Act 81, Act 113, Act 214, Act 216, and Act 133)

These amendments raised the maximum aggregate amount of $20,000 to $25,000 whenever it applied to limits or served as a basis for compensation of death or disability limits. Additionally, the Legislature increased the ceiling and floor limits on the average weekly wage earnings used in the percentage computation of death benefits to $30 and $112.50, respectively. Benefit increases to $75 were made for permanent total disability, temporary total disability, and permanent partial disability. Further, the maximum weekly benefit for temporary partial disability was raised to $50.

The maximum amount of compensation for disfigurement was also increased to $7,000 and the previous restriction to cases affecting the face and head were eliminated. The Legislature also restored the previous limit of 312 weeks for the loss of an arm, and the schedule for permanent partial disability was revised to the same number of weeks as the Longshoremen's and Harbor Workers' Act. Additionally, a procedural amendment changed the provisions governing time specified for introducing claims for compensations and the cost of unsuccessful appeals initiated by employers.

1959 Amendments (Session Laws of Hawaii 1959, Act 48, Act 78, Act 185, Act 240, and Act 241)

The significance of the amendments passed in 1959 was the Legislature's decision to create a **presumption clause.** This amendment established that a claim submitted in proceedings for compensation was one properly made and for a compensable injury.

Further, the amendments also extended coverage to elective officials, set a statutory minimum of $2,000 for death benefits, raised the rate of benefits for partial total disability after exhaustion, and raised the maximum weekly benefit payment for permanent partial disability to $112.50. Revisions were also made to expand the provisions regulating the determination of average weekly wages, time limits on claims for compensation, costs of frivolous proceedings, and the right of the employee to institute or join a third party action.

Additionally, the amendments added compensation for disfigurement as an addition to that for other scheduled injuries.

1961 Amendments (Session Laws of Hawaii 1961, Act 5, Act 115, and Act 152)

The Legislative Session of 1961 is significant in that it was the first session after Hawaii was admitted to the Union and achieved statehood. The first State Legislature amended the law to specifically authorize the Director to promulgate a fee schedule for medical, surgical and hospital services. Further, the amendments enlarged the statute of limitations with special limitations added for cases involving claims based on certain poisons or radioactive exposure. Finally, the amendments also increased the maximum amount payable for burial expenses to $1,000.

The Legislature also requested that the Legislative Reference Bureau examine the effects of the amendments produced in prior territorial legislative sessions and to clarify and recodify the workers' compensation statutes.

On November 30, 1961, the Director transferred the Division of Industrial Safety (present day HIOSH) to independent status after having spent 15 years as a part of the Department's Workmen's Compensation Division.

1963 Amendments (Session Laws of Hawaii 1961, Act 64, Act 115, and Act 152)

In Retrospect, Prior to 1963

The Legislative Reference Bureau obtained the assistance of **Professor Stefan A. Riesenfeld** from the University of California – Berkeley to conduct the examination and recodification of the workmen's compensation statute. **Professor Riesenfeld is widely credited with rewriting the State's workers' compensation laws into its present form.** His analysis of Hawaii's statutes found it to be largely inconsistent with itself, stating that the law bore, "The telling marks of patchwork, and many incongruities had crept into the once fairly consistent scheme of legislation."

In his report to the Legislature on behalf of the Legislative Reference Bureau, Professor Riesenfeld recommended the following four major proposals:

1. The Workmen's Compensation Division should be organized to provide for the initial hearing of contested cases by independent hearings officers and for the review of cases by a single expert appeals board;
2. Compensation insurance rates should be established by a properly constituted expert board;
3. Rehabilitation, both therapeutically and vocationally, should be accepted as one of the principal goals of the workmen's compensation program and new emphasis given to achieving this goal; and
4. Necessary steps should be taken to reestablish and ensure the continuing solvency of the special compensation fund.

The amendments of 1963 were expansive and largely adopted and incorporated into law proposals number 3 and 4, while proposal numbers 1 and 2 would be incorporated in later legislative sessions.

Additionally, the 1963 amendments provided increased benefits for permanent partial disability ($25,000 maximum increased to $35,000), and rehabilitation ($1,000 in any one case increased to $5,000), and death benefits to an unmarried child incapable of self-support (to be paid for life). Further, the Legislature also amended the law to provide coverage to off-duty police officers injured, disabled, or killed while engaged in the apprehension of violators of the law or in the preservation of peace, deemed to be caused by accidents arising out of and in the course of employment.

The most important result of the recodification was the clarification of certain provisions of the workers' compensation law that had been widely criticized as "litigiously prolific" by several courts, including the Supreme Court.

One year later, the United States Department of Labor – Bureau of Labor Standards rated Hawaii's workers' compensation law as the most liberal workmen's compensation law in the United States. (See Bulletin 212, Revised 1964)

1965 Amendments (Session Laws of Hawaii 1965, Act 59, Act 69, Act 99, Act 106, Act 152, and Act 156)

The 1965 amendments were largely "housekeeping" in nature by adjusting language (jury trials, reopening of cases, etc.) and benefits (disfigurement, disability, and weekly wages).

1967 Amendments (Session Laws of Hawaii 1967, Act 16, Act 53, Act 54, Act 88, Act 124, Act 138, Act 180, Act 213, and Act 257)

The amendments of 1967 increased the maximum payable benefits for death from $25,000 to $35,000 and provided various "housekeeping" amendments to statutes relating to alien dependents, appeals, average weekly wage computation, disability benefits, medical services and supplies, and employer liability. Additionally, public employees became entitled to the difference between their benefits while on workers' compensation and their regular wage.

1968 Amendments (Session Laws of Hawaii 1968, Act 57)

These Amendments extended coverage to public board members who are injured while volunteering their time to the State.

1969 Amendments (Session Laws of Hawaii 1969, Act 13, Act 17, Act 18, Act 21, Act 25, Act 31, and Act 85)

The Legislature codified Professor Riesenfeld's first proposal and created the three-member Labor and Industrial Appeals Board to decide appeals from decisions and orders of the Director of Labor and Industrial Relations.

Additionally, the amendments provided various "housekeeping" amendments to clarify statutes relating to the compromise of claims, rights and remedies against third parties, medical reports and expenses of litigation. There were also adjustments to the payment of benefits in relation to permanent partial disability and temporary total disability.

1970 Amendments (Session Laws of Hawaii 1971, Act 53, Act 58, Act 100, Act 126, Act 175, Act 200, and Act 208)

The amendments of 1971 provided various "housekeeping" amendments to clarify statutes or adjust benefits relating to average weekly wages, limited liability in concurrent employment, the definition of a physician, and compensation for permanent partial disability.

1971 Amendments (Session Laws of Hawaii 1971, Act 24, Act 25, Act 85, Act 86, Act 87, Act 101, Act 148, and Act 159)

These amendments increased employer liability for funeral and burial expenses to $1,500. Additionally, they increased the survivor benefit duration to 22 years of age, if an unmarried dependent child is a full-time undergraduate student at a four-year college.

Employer liability to the Special Compensation Fund was increased for non-dependency death cases from $2,000 to $8,775. Additionally, there was a mandate that employers post information regarding employee rights and benefits provided by the state's workers' compensation law.

1972 Amendments (Session Laws of Hawaii 1972, Act 3, Act 13, Act 42, Act 54, and Act 60)

The Legislature eliminated the employer's maximum liability cap for income and indemnity benefits, which was set at $35,000. Additionally, the Legislature also extended coverage to volunteer deputy fish and game wardens if they were injured while performing voluntary service for the state.

Additional amendments clarified employer liability for payment and special assessments, enforcement of decision made by the Director, and required reports from hospitals and physicians.

1973 Amendments (Session Laws of Hawaii 1973, Act 10, Act 11, Act 12, Act 47, Act 64, Act 78, Act 101, Act 144, and Act 183)

The 1973 Amendments mandated the Director of Labor and Industrial Relations to set charges for medical care using the Consumer Price Index for the USDOL for annual adjustment.

Additionally, the amendments also allowed claimants to reopen their workers' compensation case and/or allowed for future medical benefits regardless of an approved

settlement agreed to by all parties. The amendments also clarified further requirements regarding reports from medical providers, qualifications for temporary partial disability, death benefits, medical care, and the Special Compensation Fund.

1974 Amendments (Session Laws of Hawaii 1974, Act 8, Act 52, Act 151, Act 153, and Act 157)

The 1974 amendments shortened the period within which a decision of the Director may be appealed from 30 to 20 days. The amendments also conformed death benefits for widowers to that of widows and *increased the maximum weekly benefits from $112.50 to the State's average weekly wage.*

Additional amendments clarified and adjusted statutes regarding the reopening of cases, dependent benefits, weekly benefit adjustments, and commutation of periodic payments.

1975 Amendments (Session Laws of Hawaii 1975, Act 4, Act 41, Act 68, and Act 107)

The 1975 amendments changed the term "workmen's compensation" to the gender neutral term "workers' compensation". Additionally, the amendments extended coverage to include domestic workers earning $225 or more from any one employer and decreased from seven days to five days the compensation payable for the first two days of temporary total disability.

1976 Amendments (Session Laws of Hawaii 1976, Act 17)

These amendments increased the allowable maximum monthly sum for services of an attendant from $300 to a sum not more than four times the effective maximum weekly benefit rate.

1977 Amendments (Session Laws of Hawaii 1977, Act 87)

The amendments of 1977 centered on funeral and burial benefits, as the Legislature mandated that benefits may be paid to heirs or estates of the deceased if the aforementioned had a prepaid funeral and/or burial plan.

1978 Amendments (Session Laws of Hawaii 1978, Act 110, Act 201)

The 1978 amendments exempted domestic workers authorized by the Department of Social Services and Housing (present day Department of Human Services ["DHS"]) from workers' compensation coverage. The Amendments also made it illegal for an employer to suspend or discharge an employee who has suffered a work-related injury covered by workers' compensation.

1979 Amendments (Session Laws of Hawaii 1979, Act 40, Act 66, Act 114, and Act 132)

The amendments of 1979 expanded the “exemption from” coverage to corporate officers who own 25% of the corporation in which there are no employees. They also clarified and amended statutes concerning injury from asbestos, revision of the medical care fee schedule, and temporary total disability.

1980 Amendments (Session Laws of Hawaii 1980, Act 100, Act 224, Act 298)

Act 100 added section 386-8.5 to grant labor unions immunity from civil actions from their members on the same basis as employers from their employees under the workers' compensation law in the enforcement of "safety or health provisions".

Act 224 improved the delivery of rehabilitation services to injured employees who become permanently disabled and provided incentives for participation in rehabilitation programs. The Act also mandated a rehabilitation unit within the Department to carry out the purpose of the Act.

Act 298 added a new section to provide a one-time benefit rate adjustment to workers who have been totally and continuously disabled and are receiving low weekly compensation benefits based on previously legislated maximum benefit rates.

1981 Amendments (Session Laws of Hawaii 1981, Act 114)

Act 114 clarified the statutory language in section 386-35 so that permanently and totally disabled employees are entitled to only one supplemental allowance and not from both the responsible employer and the Special Compensation Fund. The Act also made it clear that all permanently and totally disabled employees whose weekly benefit is less than that in effect on June 18, 1980, shall be entitled to the supplemental allowance regardless of when the determination of permanent total disability was made.

1982 Amendments (Session Laws of Hawaii 1982, Act 51, Act 52, Act 59, Act 93, Act 98, Act 193)

Act 51 established December 31 as the annual injury cost reporting date instead of bi-annually on June 30 and December 31. The Act also changed the date of the assessment notice for self-insured employers from May 1 to August 15, with the payment due on September 30 instead of on June 30.

Act 52 extended funeral expenses to a maximum of ten times the maximum weekly benefit rate and burial expenses to five times the maximum weekly benefit rate.

Act 59 permitted the Director of Labor and Industrial Relations to initially approve compromises when the claimant desires to waive statutory rights to reopen or future medical benefits.

Act 93 required the Special Compensation Fund to pay the balance of benefits after the employer has paid 104 weeks of benefits in the following situations: (1) to a permanently partially disabled worker who had a previous disability; (2) to a worker with

a previous disability who is considered permanently and totally disabled; (3) to a worker's dependents if the worker had a previous disability and dies from an industrial injury (the employer pays 104 weeks of death benefits). If the previous permanent partial disability is less than 32 weeks, the employer is responsible for the actual permanent disability or for death benefits.

Act 98 increased the penalty for making a false or misleading statement or representation under the workers' compensation law from up to $250 to not to exceed $1,000.

Act 193 entitled a "hanai" child, toward whom the employee had assumed the duties and responsibilities of a parent, the same rights as other children enumerated in section 386-2.

1983 Amendments (Session Laws of Hawaii 1983, Act 299)

Act 299 provided for a moratorium on changes in the workers' compensation insurance premium rates for the calendar year 1984.

1984 Amendments (Session Laws of Hawaii 1984, Act 284)

Act 284 clarified and declared the intent of the legislation in regard to subsequent injuries occurring on or after May 15, 1982, which would increase a worker's disability. The Act encouraged employers to retain an injured employee without penalizing those employers. Consequently, the Special Compensation Fund would be used to apportion liability in order to fully compensate an injured employee and encourage employers by limiting their liabilities to the effects of the last injury during employment.

1985 Amendments (Session Laws of Hawaii 1985, Act 296)

Act 296 amended the workers' compensation law to lessen the number of work-connected injuries and illnesses and reduce costs by providing the statement of vocational rehabilitation purposes similar to that in the current administrative rules at the time, replacing the two-day waiting period with a three calendar day waiting period and eliminating the five-day recapture provision. Also, a new definition was added to section 1 of "health care provider" to include, in addition to the professions presently defined as "physicians," podiatrists and psychologists.

Additionally, the amendments also required the Department to issue a frequency of treatment guidelines for health care providers with sanctions against those who do not comply. Separate fee schedules for the various classes of health care providers would also be necessary, as well as replacing the current fraud provision with a more comprehensive provision which also increases the maximum penalty to $2,500. Further, the amendments also required the Department to render decisions within 60 days after conclusion of a hearing, with an extension for good cause, providing all parties agree, thus reducing the reopening period from 10 to 8 years; and requiring insurance carriers to offer workers' compensation insurance with a provision for a deductible amount for medical benefits.

1986 Amendments (Session Laws of Hawaii 1986, Act 132)

Act 132 added a new section requiring all employers, whose principle place of business is outside the State, to register with the Director prior to commencing employment within the State and furnish to the Director, a notice of insurance and a copy of the insurance policy.

1987 Amendments (Session Laws of Hawaii 1987, Act 120, Act 121, Act 374)

Act 120 adjusted the date on which the Department determines the increases or decreases in medical fees as published in the medical fee schedule. At that time, section 386-21 provided that adjustments be based on the Consumer Price Index for the Honolulu region prepared by the Bureau of Labor Statistics of the USDOL.

Act 121 provided volunteer boating enforcement officers with the same workers' compensation benefits that were being provided to public board members, reserve police officers, voluntary deputy fish and game wardens, and volunteer firefighters.

Act 374 amended the definition of "physician" to include psychologists under section 386-1.

1988 Amendments (Session Laws of Hawaii 1988, Act 35, Act 37)

Act 35 required employers/insurance carriers to submit insurance contract notices on a form prescribed by the Director instead of a copy of the insurance contract.

Act 37 strengthened compliance with the workers' compensation law by increasing penalties in sections 386-31, 386-94, 386-95, 386-96, 386-123, and 386-129.

1989 Amendments (Session Laws of Hawaii 1989, Act 24, Act 56, Act 243, Act 300)

Act 24 required out-of-state employers to file a notice of insurance pursuant to section 386-122, instead of section 431-104, which had been repealed.

Act 56 deleted podiatrists from the "medical care" definition and added them to the "physician" definition.

Act 243 increased the maximum optional medical deductible range on workers' compensation policies from $500 to $2500.

Act 300 provided construction design professionals immunity from civil actions for any injury on the project resulting for the employer's failure to comply with safety standards on the project.

1991 Amendments (Session Laws of Hawaii 1991, Act 71, Act 72, Act 78, Act 79, Act 98, Act 107)

Act 71 provided benefit rate adjustments effective January 1, 1992, and every ten years thereafter, to permanently total disabled workers who are receiving weekly compensation benefits based on previously legislated maximum benefit rates.

Act 72 changed the factor used in determining maximum and minimum weekly benefits for dependents as prescribed by section 386-41 from .667 to .6667.

Act 78 required all insurers to maintain a complete local claims office or engage an independent claims adjusting service as their claims agent in this State with draft authority by January 1, 1992.

Act 79 clarified that captive insurance companies under Chapter 431 are required to comply with all provisions of Chapter 386.

Act 98 changed the amount the employer pays for any one death into the Special Compensation Fund from $8775 to "twenty-five percent of three hundred and twelve times the effective maximum weekly benefit rate provided in section 386-31." The amendment also awarded the amount for any one death to the nondependent parent or parents instead of the Special Compensation Fund.

Act 107 provided for a general fine of up to $250 for each offense for violations of the workers' compensation law and related administrative rules.

1992 Amendments (Session Laws of Hawaii 1992, Act 67)

Act 67 amended the partial disability provision to require compensation for permanent partial disability to be in the amount determined by multiplying the effective maximum weekly benefit rate prescribed under the total disability provision by the number of weeks specified for the disability.

1993 Amendments (Session Laws of Hawaii 1993, Act 123, Act 254, Act 255, Act 301, Act 363)

Act 123 authorized the Director of Labor and Industrial Relations to determine and receive the Workers' Compensation Special Compensation Fund assessment from self-insured employers.

Act 254 authorized the Director of Labor and Industrial Relations to assess administrative penalties up to $5,000, and deleted the criminal penalty provision of possible imprisonment.

Act 255 clarified that the Circuit Court can render a judgment to enforce the Director's decision assessing a penalty, awarding compensation, or other relief.

Act 301 authorized the Director of Labor and Industrial Relations to assess administrative penalties for persons claiming unapproved fees under the workers' compensation law, and deleted the criminal penalty provision of possible imprisonment.

Act 363 excluded from the definition of "employment", those services performed by an individual for a corporation if the individual owns at least 50% of that corporation, and prohibits an employer from requiring an employee to incorporate as a condition of employment.

1995 Amendments (Session Laws of Hawaii 1995, Act 218, Act 231, and Act 234)

1915, 1963, 1985, and 1995 signify the four different years that the Hawaii State Legislature undertook drastic revisions to the State's workers' compensation law. In 1995, several hundred individual businesses and employer organizations formed the Haku Alliance to lobby the Legislature for significant reform of the state's workers' compensation system. The system had become one of the more costly systems in the nation and was crippling Hawaii's business community.

The reform was primarily targeted at controlling medical costs by establishing a medical fee schedule, which generally limits the reimbursement rate for medical services at 110% over Medicare. This Act also provided clear guidelines for what constitutes fraud, limited provider care, and provided penalties and incentives for safety and health programs to reduce workplace injuries.

The amendments also established the special fund for the administration of workers' compensation insurance in the Office of the State Insurance Commissioner to administer workers' compensation insurance. Additionally, the reforms also enacted an assigned risk pool for high risk industries that were unable to obtain insurance due to their risk.

The Legislature also mandated that the Department of Labor and Industrial Relations and the Insurance Commissioner do a comprehensive feasibility study of coordinated health care delivery systems for consideration by the Legislature as a potential alternative to the current workers' compensation system.

1996 Amendments (Session Laws of Hawaii 1996, Act 260 and Act 261)

The second attempt to control workers' compensation costs occurred one year later in 1996 with the enactment of Act 261, which established the Hawaii Employers' Mutual Insurance Company ("HEMIC"). The Legislature found that despite the reforms passed in 1995, many of Hawaii's small businesses were unable to find affordable insurance and were being unfairly placed in the State's assigned risk pool, which was established for high-risk employers. HEMIC was created to provide workers' compensation coverage to not only the high-risk employers, but to those small business employers who were unable to obtain insurance otherwise. In 1996, the State's assigned risk pool had 30% of Hawaii's businesses.

Additionally, Act 260 sought to undo the amendments of Act 234 of 1995 which amended section 386-26, HRS, "Guidelines on Frequency of Treatment and Reasonable Utilization of Health care and Services". In 1995, this section was amended to provide treatment guidelines and utilization in which the "…frequency and extent of treatment shall not exceed the nature of the injury and process a recovery requires…" In 1996, the Legislature repealed the amendment and mandated that the Director of Labor and Industrial Relations develop treatment and utilization guidelines for medical providers.

Instead of developing the treatment and utilization guidelines mandated from the Legislature, the Department instead adopted into the administrative rules original language repealed by the Legislature: "…frequency and extent of treatment shall not exceed the nature of the injury and process a recovery requires…"

1997 Amendments (Session Laws of Hawaii 1997, Act 18, Act 81, Act 84, Act 300, and Act 344)

These amendments were primarily "housekeeping" in nature as they sought to clarify and make additional changes to the school-to-work-based learning program, HEMIC, the insurance premium discount for employers with exceptional safety and health programs, and rate filing published by the State Insurance Commissioner.

1998 Amendments (Session Laws of Hawaii 1998, Act 16, Act 71, Act 105, Act 115, Act 166, Act 191, Act 224, Act 252, Act 256, Act 281)

In 1998 the Legislature enacted many amendments clarifying and expanding statutes regarding rate filings, employer liability for concurrent employment, and expansion of coverage to volunteer medical emergency response personnel.

However, the more significant amendments enacted by the Legislature to control workers' compensation costs were:

Act 166 which allowed for the establishment and oversight of coordinated care organizations as a pilot project to sunset in 2002. *Act 166 (coordinated care) was largely considered a failure and was allowed to sunset. The primary reason that Act 166 failed was due in large part to the fact that while employers could contract with a coordinated care organization for workers' compensation, state law did not require the injured employee to attend, which made Act 166 ineffective.*

Act 252 established the governmental oversight council for HEMIC.

Act 224 established that a mental stress claim resulting solely from good faith disciplinary action by the employer was not compensable. Act 224 was in response to Mitchell v. State of Hawaii, DOE, 85 Haw. 250 (1997), in which the Hawaii Supreme Court held that a teacher's stress-related injury resulting from disciplinary action taken by the employer in response to her alleged misconduct was compensable under the workers' compensation law.

However, under this 1998 amendment, injuries arising from all other good faith personnel actions are still compensable. *For example, if the employee receives mental stress while trying to attain a promotion, it is compensable under Hawaii law.*

Act 256 amended the workers' compensation statute to allow claimants to self-refer themselves to vocational rehabilitation. Originally, claimants were required to get approval from the Director, (who oversaw all providers and all plans) to receive vocational rehabilitation. Under the current law, the claimant selects his or her own vocational rehabilitation plan and vocational counselor, without any input or oversight by the employer or Director.

1999 Amendments (Session Laws of Hawaii 1999, Act 163 and Act 222)

The amendments of 1999 were largely "housekeeping" in nature in that they made technical and clarifying amendments to the state insurance code and expanded medical providers to include advanced practice registered nurses.

2000 Amendments (Session Laws of Hawaii 2000, Act 46, Act 69, Act 103, Act 264, and Act 288)

The Legislature made few amendments in 2000, including expanding employer liability for subsequent injuries to include not only permanent total disability, but also permanent partial disability. They also expanded the terms "medical care" and "medical services" in workers' compensation to include physical therapist assistants. Additionally, expenses from the Special Compensation Fund were expanded to include administrative expenses.

2001 Amendments (Session Laws of Hawaii 2001, Act 242)

Act 242 renamed the school-to-work program.

2002 Amendments (Session Laws of Hawaii 2002, Act 67, Act 126, Act 178, Act 215, Act 221 and Act 228)

These amendments were mostly "housekeeping" in nature as they clarified or expanded statutes concerning health coverage in third party claims, independent bill reviewers, prevailing wage law, and when employers were required to submit injury reports.

2003 Amendments (Session Laws of Hawaii 2003, Act 52 and Act 171)

The 2003 amendments expanded medical care and medical services to occupational therapists and assistants and ensured that contractors bidding on public projects carried workers' compensation insurance.

2004 Amendments (Session Laws of Hawaii 2004, Act 39, Act 175, and Act 202)

The 2004 amendments clarified and expanded requirements on appealing orders or rulings and required pest control operators to show proof of coverage for licensing.

Appendix II

STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

Amendments to Chapters 12-10 and 12-15
Hawaii Administrative Rules

April 20, 2005

SUMMARY

1. §12-10-1 is amended.

2. §12-10-65 is amended.

3. §12-10-66 is amended.

4. §12-10-67 is repealed.

5. §12-10-69 is amended.

6. A new §12-10-72.1 is added.

7. §12-10-94 is amended.

8. §12-15-1 is amended.

9. §12-15-30 is amended.

10. §12-15-31 is amended.

11. §12-15-32 is amended.

12. §12-15-34 is repealed.

13. §12-15-85 is amended.

§12-10-1 Definitions. As used in this chapter:

"Able to resume work" means an industrially injured worker's injury has stabilized after a period of recovery and the worker is capable of performing work in an occupation for which the worker has received previous training or for which the worker had demonstrated aptitude.

"Appellate board" shall be as defined in section 386-1, HRS.

"Adjuster" means an individual, partnership, corporation, or others, who is in the business of adjusting workers' compensation insurance claims for a self-insured employer, insurer, or others.

"Attending physician" means a physician, as defined in section 386-1, who is primarily responsible for the treatment and direction of care of a work injury. There shall not be more than one attending physician. In the event an injured employee is treated by more than one physician in accordance with section 12-15-40, the employee shall designate a physician as the attending physician.

"Compensation" shall be as defined in section 386-1, HRS.

"Covered employment" shall be as defined in section 386-1, HRS.

"Days" means calendar days, unless otherwise provided.

"Department" shall be as defined in section 386-1, HRS.

"Director" shall be as defined in section 386-1, HRS.

"Disability" shall be as defined in section 386-1, HRS.

"Disciplinary action" means any action taken in good faith by the employer relating to or used for discipline. Disciplinary action shall include the actual sanction imposed upon an injured employee for the purpose of discipline, as well as any action taken in good faith by an employer that is a part of the

disciplinary process, even if no sanction or punishment is ultimately imposed. Examples of disciplinary actions include, but are not limited to, where the employer takes good faith corrective or punitive action:

(1) to produce a specific type or pattern of behavior;

(2) to obtain conformity;

(3) to train or correct;

(4) to impose order on or improve work habits; and

(5) to impose order on or improve the worksite.

If a collective bargaining agreement or other employment agreement specifies a different standard than good faith for disciplinary actions, the standards specified in the agreement shall apply.

"Disqualified health care provider" means a health care provider barred under section 386-27, HRS, from providing health care services to a person who has suffered a work injury.

"Employee" shall be as defined in section 386-1, HRS.

"Employee in comparable employment" shall be as defined in section 386-1, HRS.

"Employee's designated representative", for the purpose of section 386-31(b)(1), HRS, means the representative of record of the employee, such as the employee's attorney or union representative. As used in this chapter, employee shall include the employee's representative unless clearly indicated otherwise.

"Employer", as defined in section 386-1, HRS, includes a self-insured employer or the self-insured employer's adjuster or designated representative unless clearly indicated otherwise, the insurer of an employer, or an employer who has failed to comply with section 386-121, HRS.

"Employer's designated representative", for the purpose of section 386-31(b)(1), HRS, shall include:

(1) A self-insured employer's adjuster or attorney of record;

(2) An insured employer's insurer, adjuster, or attorney of record; or

(3) The adjuster or attorney of record of an uninsured employer.

"Employment" shall be as defined in section 386-1, HRS.

"Employment for personal, family, or household purposes" includes but is not limited to:

(1) Services performed by an individual in constructing, repairing, or maintaining employer's private place of abode or dwelling.

(2) Domestic, valet, custodial, or babysitting services performed by an individual for an employer in or about a private place of abode.

(3) Chauffeuring or personal safeguarding services performed by an individual for an employer or members of the employer's family.

"Full-time student" means an individual who is considered a regular full-time student by the educational institution at which the individual is enrolled or registered.

"Good Cause" means a compelling reason for failing to perform an act required by law, unless otherwise provided. The party must prove that the failure to perform any act required by law was not due to willful neglect. A finding for good cause will be based upon the circumstances in each case.

"Hanai child" means a child who, prior to the industrial injury, is taken permanently to reside, be educated, and reared by someone other than the natural parents, traditionally a grandparent or other relative.

"Health care provider" shall be as defined in section 386-1, HRS.

"Higher wages" means a higher regular rate of pay per unit of time.

"Insured employer" means an employer who obtains workers' compensation insurance from an insurer pursuant to section 386-121(a)(1), HRS.

"Insurer" means any insurance company authorized by the insurance commissioner to underwrite, sell, or transact workers' compensation insurance in the State of Hawaii.

"Medical care", "medical services", or "medical supplies" shall be as defined in section 386-1, HRS.

"Medical stabilization" means that no further improvement in the injured employee's work-related condition can reasonably be expected from curative health care or the passage of time. Medical stabilization is also deemed to have occurred when the injured employee refuses to undergo further diagnostic tests or treatment which the health care provider believes will greatly aid in the employee's recovery.

"Personal injury" shall be as defined in section 386-1, HRS.

"Physician" shall be as defined in section 386-1, HRS.

"Self-insured employer" means an employer authorized by the director to comply with chapter 386, HRS, pursuant to section 386-121(a)(2) or (3), HRS.

"Sixty-six and two-thirds per cent", as required by sections 386-31 and 386-32, HRS, means the factor .6667.

"State average weekly wage" shall be as defined in section 386-1, HRS.

"This statute" or "the statute" means chapter 386, HRS, unless otherwise specified.

"Total disability" shall be as defined in section 386-1, HRS.

"Trade, business, occupation, or profession" shall be as defined in section 386-1, HRS.

"Uninsured employer" means an employer who has failed to comply with section 386-121, HRS.

"Wages" shall be as defined in section 386-1, HRS.

"Week" or "workweek" means a fixed and regularly recurring period of seven consecutive days.

"Work injury" shall be as defined in section 386-1, HRS. [Eff: 4/30/81; am 12/17/82; am 11/29/85; am] (Auth: HRS §§386-27, 386-72) (Imp: HRS §§386-1, 386-2, 386-3, 386-21, 386-24, 386-25, 386-27, 386-31, 386-32, 386-42, 386-43, 386-51, 386-71, 386-91, 386-121)

§12-10-65 Discovery. Discovery in workers' compensation cases before the Director is limited to:

(a) **Interrogatories and requests for production of documents.** One set of written interrogatories and requests for production of documents may be served upon each adverse party. The number of interrogatories, including the requests for production of documents, to any one party shall not exceed 20, each of which shall consist of a single question or request. The responses to the interrogatories and production of documents shall be served on all parties within 20 days of mailing of the interrogatories and requests. The responses to interrogatories and the requests for production of documents may not be submitted to the director later than 15 days prior to hearing.

(b) **Depositions.** For the purpose of obtaining any matter, not privileged, which is relevant to the subject matter involved in the pending action, the director may, upon application, order the taking of relevant testimony by deposition upon oral examination. Permission to take a deposition of a party will be granted only when it is reasonable and necessary such as when there is a specific showing of the following:

(1) That a party who has been served with written interrogatories or requests for production of documents and has failed to respond to the interrogatories or production of documents; or

(2) That the responses to the written set of interrogatories are insufficient; or

(3) All parties agree to the taking of a deposition.

(c) **Subpoenas**.

(1) Subpoenas requiring the attendance of witnesses at a hearing before a hearings officer or for the taking of a deposition or the production of documentary evidence from

any place within the State at any designated place of hearing may be issued by the director or a duly authorized representative. The employer shall serve the injured employee with a copy of a medical record subpoena unless the employer has previously obtained the employee's authorization to examine the employee's medical records. Should the employee subpoena medical records, the employer shall be served with a copy of the medical record subpoena.

(2) The party subpoenaing the records shall serve these records within fifteen calendar days of their receipt upon all other parties. These records shall be submitted by the party requesting the subpoena to the director fifteen days before the date of the hearing or upon request by the director.

(3) A party who desires to enforce the director's subpoena shall seek enforcement from a court of competent jurisdiction.

(d) **Witness fees**. A subpoenaed witness shall be entitled to the same witness fee as in the case of a witness subpoenaed to testify before the circuit court.

(e) **Duty to Supplement.** Each party is under a continuing duty to timely supplement or amend responses to discovery up to the date of the hearing.

(f) **Failure to Comply with Discovery.** If any party fails to comply with this rule and any action governed by it, the director may impose sanctions not to exceed $250.00 for each offense or preclude the party from presenting such evidence at the hearing.

(g) **Additional Discovery.** Upon agreement of the parties or upon showing that discovery is reasonable and necessary, the director may allow additional discovery, may limit discovery, or may modify the time limits set forth in this rule. [Eff: 4/30/81; am

2/11/91; am] (Auth: HRS §386-72) (Imp: HRS §§91-2(2), 386-86)

§12-10-66 Alternative resolution. (a) In lieu of a hearing before the Director, at anytime after a claim for compensation is made and before the director renders a decision, the parties may agree in writing to have any controversy arising under this chapter be decided by a referee paid for by the parties.

(b) **Appointment of referee**. Before a referee can conduct a hearing, the parties shall submit the agreed upon referee's name to the Director for appointment to serve as a referee. The referee shall be a neutral person. An individual who has a known, direct, and material interest in the outcome of the controversy or a known, existing, and substantial relationship with a party may not serve as a referee, unless that interest is disclosed, and any conflict is waived by the parties.

(c) **Costs**. Unless the parties otherwise agree, the costs and fees of the alternative resolution process shall be divided equally between the parties.

(d) **Stay of proceedings before the director**. If the parties agree to have any controversy referred to a referee, the director shall stay all actions or proceedings until the director issues a decision based on the referee's recommended decision.

(e) **Discovery and other matters**. Chapter 386 and its rules remain applicable to proceedings before the referee except that requests shall be directed to and recommended decisions shall be made by the referee instead of the director.

(f) **Referee's recommended decision**. The referee shall issue and submit the referee's recommended decision to the Director no later than sixty days after the hearing, and shall deliver the recommended decision to all parties personally or by registered or certified mail.

(g) **Approval of recommended decision.** The Director shall review the referee's recommended decision to determine whether the recommended decision is in compliance with chapter 386. If the recommended

decision is in compliance with chapter 386, the Director shall approve the recommended decision and upon the director's approval, the recommended decision has the same force and effect as a director's decision rendered under chapter 386, and it may be enforced as if it had been rendered in an action before the director. If the recommended decision does not comply with chapter 386, the Director may modify or vacate the recommended decision. If the director vacates the recommended decision, the parties may resubmit the controversy to the referee.

(h) **Appeals.** Except when the parties have agreed that no appeal may be taken and where the director has not modified or vacated the referee's recommended decision, the parties may appeal the director's decision in accordance with section 386-87.

(i) **Applicable law.** Chapter 386 and Hawaii Administrative Rules title 12, chapters 10, 14, and 15 are applicable to the proceedings before the referee.

(j) **Mediation**. At anytime after a claim for compensation is made and before the director renders a decision, the parties may agree to resolve any controversy regarding this chapter through mediation by a mediator agreed upon by the parties. Unless otherwise provided in the agreement, the costs and fees of mediation shall be divided equally between the parties. Upon the successful conclusion of the mediation, the parties shall submit the settlement agreement to the director for approval. If any controversy remains unresolved after the mediation, the parties may request the director resolve the controversy after providing the parties the opportunity to be heard in accordance with chapter 386. [Eff: 4/30/81; am 2/11/91; am] (Auth: HRS §386-72) (Imp: HRS §§91-2(2), 386-86)

§12-10-67 REPEALED. [Eff: 4/30/81; R]

§12-10-69 **Attorney's fees**. (a) Within ten calendar days following the filing of a final decision and order or upon the filing of a stipulation and settlement agreement, attorneys seeking approval of fees and costs claims pursuant to section 386-94, HRS, shall file with the department a request for approval of attorney's fees and costs setting forth a detailed breakdown of the time expended and costs incurred in each activity up to and including the date of the decision. The request shall be served on those parties against which the fees and costs claims are to be assessed. Any party objecting to approval of a request may file written objections no later than ten calendar days after service. Absent objections, agreement shall be presumed. No request for approval of attorney's fees and costs claims or agreement to pay attorney's fees and costs claims shall be valid until approved by the director. The director may require additional details and justification of time billed or costs claims. The director shall disapprove requests which are not served properly or filed timely, except for good cause.

(b) The director shall determine the maximum allowable hourly rate of the attorney and reasonable time allowable on each workers' compensation case. In approving attorney's fee requests, the director will consider the approved hourly rate of the attorney and the number of hours approved. Factors to be considered in determining an attorney's approved hourly rate include the number of years practicing as an attorney, the number of cases representing workers' compensation claimants during the last three years, and any other pertinent factors that should be considered in determining the hourly rate. Factors considered in determining the number of hours allowable include the time and effort required by the complexity of the case, novelty and difficulty of issues, benefits obtained for the injured employee, and arguments made by the attorney and injured

employee. The director reserves the right to adjust the hourly rate and the number of hours requested.

(c) Costs claims such as delivery, typing, telephone (except for long distance calls), fax, and parking are considered part of the cost of doing business and shall not normally be approved unless properly justified. Claims such as photocopying and long distance telephone calls may be approved as costs if properly justified. [Eff: 12/17/82; am 2/11/91; am] (Auth: HRS §386-72) (Imp: HRS §386-94)

§12-10-72.1 **Hearings Process**. (a) **Hearings.**

(1) **Requests for hearing.** If the parties are unable to resolve a claim, dispute, or controversy arising under chapter 386, HRS, or these rules, and have been unable to resolve the contested issue informally through mediation or alternative resolution if the parties agreed to submit the matter to mediation or alternative resolution, a party may request a hearing before a hearings officer appointed by the director by filing a written application with the director on a prescribed form. The form shall contain:

(A) A statement of the issue(s) to be determined at the hearing;

(B) A statement setting forth the names and addresses of all witnesses to be presented at the hearing, and/or whose testimony will be submitted by way of a deposition transcript;

(C) A statement notifying the adverse party of their right to file a response to the application within 20 days of the application.

The application for hearing shall be mailed by certified mail by the requesting party to all parties. A certificate of mailing shall be filed with the application. If an attorney has entered an appearance for a party, mailing to the attorney is mandatory. An application will not be accepted for filing unless it contains all information required by this rule and will be returned for corrections.

(2) **Response to Application for Hearing.** Within 20 days from the receipt of the application for hearing, the adverse party shall file its response to the application on a

prescribed form with the director and shall send a copy to all parties.

(3) **Scheduling of Hearing.** A hearing shall be held within 60 days after the response is filed with the director or after the date the response is due. If at least 20 days have passed since the application has been filed, and no response has been filed, the claimant may request an expedited hearing upon a showing that without an expedited hearing to determine the merits of the dispute, the claimant will suffer severe economic hardship or severe physical or mental harm.

(4) **Place of Hearing.** All cases within the scope of these rules will be heard in the county where the disputed work injury occurred, unless other arrangements are agreed upon between the parties. The use of electronic hearings utilizing teleconference shall also be authorized if agreed upon by all parties.

(5) **Evidence at hearing.** The admissibility of evidence at the hearing shall not be governed by the rules of evidence, and all relevant oral and documentary evidence shall be admitted. Irrelevant, immaterial, or unduly repetitious material shall not be admitted into evidence. The hearings officer shall give effect to the privileges recognized by law. Documentary evidence may be received in the form of copies, provided that, upon request, all other parties to the proceeding shall be given an opportunity to compare the copy with the original. If the original is not available, a copy may still be admissible, but the unavailability of the original and the reasons therefore shall be considered by the hearings officer when

considering the weight of the documentary evidence. The hearings officer may take notice of judicially recognizable facts and of generally recognized technical or scientific facts. The director shall notify the parties whenever possible before the hearing of the material to be so noticed and the parties shall be afforded an opportunity at the hearing to contest the facts so noticed.

(6) **Witness at Hearing**. A party may not add a witness or an issue after the filing of the application or response except upon agreement of all parties, approval of the hearings officer, or for good cause shown. A party may not produce a witness at a hearing who has not been listed in the application or response or added by agreement or order, except to present rebuttal testimony or upon approval of the hearings officer for good cause shown.

(7) **Continuance of Hearing.** At any time following the scheduling of the hearing, any party may, by written motion, seek an extension of time to commence a hearing upon good cause shown. For the purpose of this paragraph, good cause includes, but is not limited to, the following:

(A) Death or incapacitation of a party or an attorney for a party;

(B) Entry or substitution of an attorney for a party a reasonable time prior to the hearing, if the entry or substitution reasonably requires an extension;

(C) Failure of a witness to appear when the witness is under a valid subpoena, which will result in prejudicing one of the parties;

(D) A showing that more time is clearly necessary to complete authorized discovery or other necessary preparation for the hearing; or

(E) Agreement of the parties that a settlement has been reached, or that settlement negotiations are ongoing and likely to be reached.

Absent additional grounds, failure of the party to timely or adequately prepare for the hearing does not constitute good cause.

(8) **Submission of reports, other documentary evidence, depositions, position statements for formal hearing.** All reports without limitation including medical and hospital reports, physicians' reports, vocational reports, and records of the employer shall be filed with the director and sent to all parties at least 15 days prior to the hearing. If not so disclosed, the reports shall not be introduced into evidence at the hearing, absent a showing of good cause. Reports and records previously provided to opposing parties do not have to be provided again. When provided, such reports and records do not have to be identified as potential hearing exhibits. A deposition transcript shall be filed 15 days before the hearing. Oral arguments at the conclusion of the hearing may be allowed at the discretion of the hearings officer. A party may file a position statement and/or proposed order upon approval of the hearings officer. Only reports and records filed and identified at the hearing which are relevant to an issue set for hearing will be considered as evidence. Testimony presented by reports, records, deposition, or

teleconference is presumed to be equivalent of in person hearing testimony.

(9) **Hearing Electronically Recorded.** For quality assurances, every hearing shall be electronically recorded. Any party in the action may request a recorded copy of the hearing. The cost of the recorded copy of the hearing is five dollars, payable to the department.

(b) **Powers of the hearings officer in conducting hearing.** The hearings officer shall have, in addition to powers as are conferred by law, the powers in conducting a hearing without limitation:

(1) To hold hearings and issue notices;

(2) To administer oaths and affirmations;

(3) To consolidate hearings or sever proceedings, provided that those actions shall be conducive to the ends of justice and shall not unduly delay the proceedings or hinder, harass, or prejudice any party;

(4) To allow and supervise discovery as deemed reasonable and necessary;

(5) To subpoena and examine witnesses;

(6) To receive relevant evidence, and to exclude evidence which is irrelevant, immaterial, repetitious, or cumulative, and accordingly may restrict lines of questioning or testimony;

(7) To regulate the course and conduct of the hearing;

(8) To regulate the manner of any examination so as to prevent the needless and unreasonable harassment or intimidation of any witness or party at the hearing;

(9) To remove disruptive individuals, including any party, legal counsel, witness, or observer;

(10) To hold conferences, including prehearing conferences, before or during the hearing

for the settlement or simplification of issues; and

(11) With the exception of scheduling or other purely administrative matters, a hearings officer presiding over the matter shall not initiate any oral communication with a party or counsel for a party unless prior written consent of all other parties or their counsel has been obtained.

(c) **Burden of Proof.** With the exception of those controverted cases that fall under section 386-85, HRS, where the burden of proof lies with the employer, the burden of proof for all other controverted cases shall lie with the party filing for hearing.

(d) **Decision on the record.** If the director determines that there is no material fact in dispute as to any contested issue, the director may elect to render a decision on the record. When the director determines that a decision on the record is appropriate, the parties shall be given 20 days to submit written statements and evidence. Ten additional days shall be given to respond. At the discretion of the director, additional time may be allowed for good cause. Copies of all written statements and evidence shall be furnished to the department and all parties.

The director shall issue a decision within 15 working days from the date the responses are filed. Request for review of a decision on the record shall be made pursuant to section 386-87, HRS.

(e) **Appeals process.**

(1) A decision of the director shall be final and conclusive between the parties, except as provided in section 386-89, HRS, unless within twenty days after a copy has been sent to each party, either party appeals therefrom to the appellate board by filing a written notice of appeal with the appellate

board or the department. In all cases of appeal filed with the department the appellate board shall be notified of the pendency thereof by the director. No compromise shall be effected in the appeal except in compliance with section 386-78.

(2) The appellate board shall hold a full hearing de novo on the appeal.

(3) The appellate board shall have power to review the findings of fact, conclusions of law and exercise of discretion by the director in hearing, determining or otherwise handling of any compensation case and may affirm, reverse or modify any compensation case upon review, or remand the case to the director for further proceedings and action.

(4) In the absence of an appeal and within thirty days after mailing of a certified copy of the appellate board's decision or order, the appellate board may, upon the application of the director or any other party, or upon its own motion, reopen the matter and thereupon may take further evidence or may modify its findings, conclusions or decisions. The time to initiate judicial review shall run from the date of mailing of the further decision if the matter has been reopened. If the application for reopening is denied, the time to initiate judicial review shall run from the date of mailing of the denial decision. [Eff:] (Auth: HRS §386-72) (Imp: HRS §§91-2(2), 386-86)

12-10-94 Self-insurance; application; duration; cancellation; revocation.

(a) Application.

(1) An employer desiring to maintain security for payment of compensation under section 386-121(a)(3), HRS, shall file:

(A) An application with the director on a form provided for this purpose.

(B) The most current audited annual financial statement with an unqualified audit opinion for a period not more than one year of the date of the application.

(C) Audited annual financial statements for the previous three years conducted in accordance with generally accepted accounting and auditing principles.

(D) A copy of the resolution of the applicant corporation board of directors authorizing the filing of the application for a certificate of consent to self-insurance and execution of the instrument of undertaking in furnishing security if required.

(E) An actuarially determined annual workers' compensation future liabilities of the applicant, prepared by a Member of the American Academy of Actuaries or other qualified loss reserve specialist approved by the director.

(2) Where an applicant for self-insurance is a subsidiary and the subsidiary cannot submit an independent current audited annual financial statement with an unqualified audit opinion, in lieu thereof an indemnity agreement approved as to form and content by the director shall be executed by the parent

corporation of the subsidiary and submitted with its application.

(3) The financial statements must demonstrate the applicant's financial solvency. To detect any unique or extraordinary circumstances facing the applicant, factors considered in financial analysis include, but are not limited to, operating income for the last five years, positive retained earnings, no adverse substantial statements in the notes to the financial statements, and a favorable Altman "Z" score. Furthermore, ratios derived from the applicant's financial statements must compare favorably to the industry averages. Ratios examined include, but are not limited to liquidity ratios, coverage ratios, leverage ratios, and operating ratios.

(4) The ability to pay workers' compensation benefits means sufficient financial strength and stability to pay obligations as they mature; pay compensation benefits and all liabilities which are likely to be incurred under the Hawaii Workers' Compensation Law; and have sufficient cash or cash equivalents, security deposit, and excess insurance to make benefit and compensation payments as they come due. The ability to pay shall be established by the maintenance of a trust account by the applicant in the amount of the actuarially determined annual workers’ compensation liabilities of the applicant.

(5) Failing to demonstrate financial solvency, the applicant may still pursue self-insurance under section 386-121(a)(2) by providing a security deposit in an amount equal to the greater of $1,000,000 or 1.5 times the actuarially determined annual

workers' compensation future liability of the applicant. The security deposit may be a surety bond, government bond, letter of credit, or certificate of deposit acceptable by the director. All forms of security shall name the director as beneficiary. When a security deposit is required, the following criteria shall apply:

(A) The director shall accept a surety bond only from companies certified by the United States department of treasury as "Companies Holding Certificates of Authority as Acceptable Sureties on Federal Bonds and as Acceptable Reinsuring Companies," as published in the Federal Register.

(B) The security deposit must name the director as obligee and must be held by the director as security for payment of all workers' compensation liabilities. The director shall retain a security deposit until all liabilities have been paid. The director shall, at its discretion, convert the deposit needed to pay claims.

(C) A security deposit in the form of a surety bond or letter of credit must include a statement that the grantor of the security deposit is required to give to the principal, the director, 60 days notice of its intent to terminate future liability. The grantor of the security deposit is not relieved of liability for injuries occurring prior to the effective date of termination. A Letter of Credit must be issued by a state chartered bank or member of the Federal Reserve System.

(6) Specific excess insurance is required of a self-insured employer. Aggregate excess insurance is required by the director for an employer unless substantive evidence is provided that it is not warranted. This evidence must include diversification of risk, industry type, financial resources, self-insured retention levels, policy limits of the specific excess policy, safety program, loss experience and other appropriate factors as determined relevant by the director.

The contract or policy of specific excess insurance and aggregate excess insurance must comply with the following:

(A) It is issued by a carrier licensed in Hawaii with a Best's Rating of A- or better and a financial size rating of VI or greater. Excess coverage issued by a carrier not rated by Best's will be considered for approval at the discretion of the director.

(B) It may be cancelled or its renewal denied only upon written notice by registered or certified mail to the other party to the policy and to the director not less than 60 days before termination by the party desiring to cancel or not renew the policy. A carrier is liable for payment of all claims that occur from the date of inception of the policy to the cancellation date of the policy.

(C) Any contract containing a commutation clause must provide that any commutation effected thereunder will not relieve the underwriter(s) of further liability in respect to claims and expenses unknown at the time of

such commutation or in regard to any claim apparently closed at the time of initial commutation which is subsequently reopened by the director or a court. If the underwriter proposes to settle the liability as provided in the commutation clause of the policy for future compensation benefits payable for accidents occurring during the term of the policy by the payment of a lump sum to the self-insurer, then not less than 60 days prior notice to such commutation must be given by the underwriter(s) or agent(s); by registered or certified mail to the director. If any commutation is effected, the director shall have the right to direct such sum be placed in trust for payment of benefits of the injured employee(s) entitled to such future payments.

(D) If a self-insurer becomes insolvent and/or fails to make benefit payments, the excess carrier, after it has been determined the retention level has been reached on the excess insurance policy, shall make payments to the entity making payments on behalf of the insolvent self-insured in the same manner as payments would have been made by the excess carrier of the self-insured.

(E) All of the following will be applied toward the retention level in the excess insurance contract:

(i) payments made by the self-insurer;

(ii) payments made on behalf of the self-insurer from the proceeds

of any security deposit as ordered by the department; and

(iii) payments made on behalf of the insolvent self-insurer by the Special Compensation Fund.

(F) Copies of the certificates and policies of the excess insurance must be filed with the department for a determination that such certificates and policies are approved by the insurance commissioner.

(7) An applicant must retain an adjustor licensed under chapter 431, HRS, to provide complete claims service to process and promptly pay claims in accordance with chapter 386, HRS.

(8) Upon approval of the self-insurance status, an Order for Self-Insurance shall be issued to the applicant and this order must be conspicuously posted at the applicant's worksite.

(b) **Duration**.

(1) Each self-insurance authorization shall be effective from date of issue to June 30 of each calendar year.

(2) The self-insurer is liable for the charges into the workers' compensation special compensation fund pursuant to section 386-154.

(3) Annual submission and review of self-insurer's audited financial statements are required for continuation of the self-insurer's self-insurance status. The most recent audited financial statement, prepared in accordance with generally accepted accounting and auditing principles, for a period ending not more than twelve months prior to June 30 of the current year, must be submitted on or before April 1 of each year.

(c) **Cancellation.** A notice of intention to cancel self-insurance shall be submitted in writing to the director within at least thirty days prior to the effective date of cancellation. If a security deposit is required pursuant to section 12-10-94(a)(4) above, this security deposit must be maintained at least twenty four months after termination of self-insurance status, provided all workers' compensation claims occurring during the period of self-insurance and workers' compensation special compensation fund assessments pursuant to section 386-154, HRS have been paid.

(d) **Revocation.** A self-insurance authorization may be revoked by the director upon notification in writing to the self-insurer, if the self-insurer fails to meet its obligation to pay workers' compensation benefits resulting from work injuries during the period of self-insurance or if the self-insurer fails to demonstrate financial solvency and ability to pay workers' compensation benefits. [Eff: 4/30/81; am] (Auth: HRS §386-72) (Imp: HRS §§91-2, 386-121)

§12-15-1 Definitions. As used in this chapter:

"Advisory panel" means the advisory panel of health care providers appointed by the director pursuant to section 386-27, HRS.

"Appellate board" shall be as defined in section 386-1, HRS.

"Attending physician" means a physician who is primarily responsible for the treatment of a work injury. There shall be only one attending physician. In the event an injured employee is treated by more than one physician in accordance with section 12-15-40, the employee shall designate a physician as the attending physician.

"Bad faith," for the purposes of section 386-27, HRS, and this chapter, requires a finding of a fraudulent, malicious, dishonest, or frivolous act or omission. Mere carelessness, bad judgment, or ordinary negligence, in and of themselves, do not constitute bad faith.

"Department" shall be as defined in section 386-1, HRS.

"Director" shall be as defined in section 386-1, HRS.

"Disability" shall be as defined in section 386-1, HRS.

"Disqualified health care provider" means a health care provider barred under section 386-27, HRS, from providing health care services to a person who has suffered a work injury.

"Employee" shall be as defined in section 386-1, HRS.

"Employer," as defined in section 386-1, HRS, includes a self-insured employer or the self-insured employer's adjuster or designated representative unless clearly indicated otherwise, the insurer of an employer, or an employer who has failed to comply with section 386-121, HRS.

"Employer's designated representative," for the purpose of section 386-31(b)(1), HRS, shall include:

(1) A self-insured employer's adjuster or attorney of record;

(2) An insured employer's insurer, adjuster, or attorney of record; or

(3) The adjuster or attorney of record of an uninsured employer.

“Evidenced based” means the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual injured employees entitled to benefits.

"Health care provider" shall be as defined in section 386-1, HRS.

"Medical care," "medical services," or "medical supplies" shall be as defined in section 386-1, HRS.

"Medical Fee Schedule" refers to the Medicare Resource Based Relative Value Scale System applicable to Hawaii and the Workers' Compensation Supplemental Medical Fee Schedule, Exhibit A, at the end of this chapter.

"Physician" shall be as defined in section 386-1, HRS.

"Provider of service" means any person or entity who is licensed, certified, recognized, or registered with the Department of Commerce and Consumer Affairs and who renders medical care, medical services, or medical supplies in accordance with chapter 386, HRS.

"Specialist" means a physician or surgeon who holds a certification as a diplomate issued by a specialty board approved by the American Medical Association or the American Dental Association.

"Therapist" means a duly registered physical therapist or an occupational therapist certified by the National Board for Certification in Occupational Therapy, who renders therapy prescribed by a physician.

"This statute" or "the statute" means chapter 386, HRS, unless otherwise specified.

"Treatment" is defined as a visit to a provider of service for the injury excluding consultations.

"Unqualified health care provider" means a health care provider who is not qualified by the director under section 386-27, HRS, to provide health care services to a person who has suffered a work injury.

"Work injury" shall be as defined in section 386-1, HRS. [Eff 1/1/96; am 12/13/04; am] (Auth: HRS §§386-21, 386-26, 386-27, 386-72) (Imp: HRS§§386-1, 386-2, 386-21, 386-23, 386-27)

§12-15-30 Provider of service responsibilities. (a) The rules herein apply to all providers of service. Additional rules pertaining to specialty areas are published in the appropriate section.

(b) The total allowed treatments shall not be performed should an injured employee recover from the injury prior to reaching the maximum allowed.

(c) The director may request evidence of treatment efficacy from the provider of service.

(d) Frequency of treatment specified in the rules herein are guidelines to improve provider of service accountability and are intended to be the presumptive prescription for health care, subject to the provisions of §12-15-32.

(e) All providers of service are required to comply with reporting requirements pursuant to chapter 386, HRS, and any related rules.

(f) The director may deny compensation to any provider of service who performs services in excess of the frequency of treatment guidelines without authorization pursuant to the statute or any related rules. [Eff 1/1/96; am] (Auth: HRS §§386-26, 386-27, 386-72) (Imp: HRS §§386-21, 386-26, 386-27, 386-94,386-96)

§12-15-31 Who may provide services. (a) All providers of service deemed qualified by the director may provide services to an injured employee. Treatment shall fall within the scope of the provider's of service license or certification to practice.

(b) Treatment rendered by an unqualified or disqualified provider of service shall not be reimbursed, except in emergencies.

(c) Any service performed by a provider of service who is not a physician as defined in section 386-l, HRS, shall be referred by and be under the direction of the attending physician. All treatment and prescription shall be in writing and in accordance with §12-15-30 and §12-15-32. [Eff 1/1/96; am] (Auth: HRS §§386-21, 386-26, 386-27, 386-72) (Imp: HRS §§386-21, 386-26, 386-27)

§12-15-32 Providers of service. (a) Frequency and extent of treatment shall be in accordance with the ODG Treatment in Workers' Comp, 3rd Edition, issued by the Work Loss Data Institute. In addition to the ODG Treatment in Workers' Comp, 3rd Edition, the director references Chapters 1-7 of the practice guides issued by the American College of Occupational and Environmental Medicine, 2nd Edition, as an expression of disability management philosophy that should be an integral part of practice within the workers' compensation system, and as an educational tool for health care providers and other participants practicing in the workers' compensation system. The treatment guidelines adopted in this subsection are presumed medically necessary and correct. The presumption is rebuttable and may be contested by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of the injury condition.

The attending physician, in addition to submitting the initial report, in accordance with section 386-96, HRS, shall submit on a form prescribed by and to be obtained from the department, entitled "Restorative Services Plan." The "Restorative Services Plan" shall include the following:

(1) Physical or mental functions necessary to perform job duties;
(2) Identify the functional deficits caused by the injury;
(3) Identify the minimal functional level to be attained in order to return to work;
(4) Provide a treatment protocol;
(5) Provide a timeline for treatment outcome; and
(6) Other pertinent information.

(b) For all injuries not covered by the ODG Treatment in Workers' Comp, 3rd Edition, or in cases in which the attending physician believes that additional treatments beyond that provided by subsection (a) are necessary or

that a treatment guideline different than that specified in subsection (a) is necessary, the attending physician shall mail a treatment plan to the employer at least fourteen calendar days prior to the start of the additional or differing treatments. The treatment plan shall detail:

(1) The attending physician's explanation for deviation from the guidelines established under §12-15-32(a), and that the plan is based upon evidence-based medical treatment guidelines generally recognized by the national medical community and that is scientifically based;
(2) That the proposed treatment plan and guidelines were developed by physicians, with involvement of actively practicing health care providers and are peer-reviewed;
(3) Projected commencement and termination dates of treatment;
(4) A clear statement as to the impression or diagnosis;
(5) Number and frequency of treatments;
(6) Modalities and procedures to be used; and
(7) An estimated total cost of services.

No treatment plan shall be valid that is not based upon evidence-based medical treatment guidelines generally recognized by the national medical community and that is scientifically based. With the exception of emergency medical services, any provider of services who exceeds the treatment guidelines without proper authorization shall be denied compensation for the unauthorized services. Unless agreed by the employee, disallowed fees shall not be charged to the injured employee.

(c) The employer may file an objection to the treatment guideline or proposed treatment plan with documentary evidence supporting the denial and a copy of the denied treatment plan with the director, copying

the attending physician and the injured employee. Both the front page of the denial and the envelope in which the denial is filed shall be clearly identified as a "TREATMENT PLAN DENIAL" in capital letters. The employer shall be responsible for payment for treatments provided under a complete treatment plan until the date the objection is filed with the director. Furthermore, the employer's objection letter must explicitly state that if the attending physician or the injured employee does not agree with the denial, they may request a review by the director of the employer's denial within fourteen calendar days after postmark of the employer's denial, and failure to do so shall be construed as acceptance of the employer's denial.

In denying medical treatment, the employer must disclose to the attending physician and employee the medically, evidenced-based criteria used as the basis of the objection.

(d) The attending physician or the injured employee may request in writing that the director review the employer's denial of the treatment plan. The request for review shall be filed with the director, copying the employer, within fourteen calendar days after postmark of the employer's denial. A copy of the denied treatment plan shall be submitted with the request for review. Both the front page of the request for review and the envelope in which the request is filed shall be clearly identified as a "REQUEST FOR REVIEW OF TREATMENT PLAN DENIAL" in capital letters. For cases not under the jurisdiction of the director at the time of the request, the injured employee shall be responsible to have the case remanded to the director's jurisdiction. Failure to file a request for review of the employer's denial with the director within fourteen calendar days after postmark of the employer's denial shall be deemed acceptance of the employer's denial. The recommended guidelines set forth in the ODG Treatment in Workers' Comp, 3rd Edition, and American College of Occupational and

Environmental Medicine's Occupational Medicine Practice Guidelines, 2nd Edition, shall be presumptively correct on the issue of extent and scope of medical treatment and utilization, regardless of date of injury. The presumption is rebuttable and may be contested by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of the injury condition.

(e) The director shall issue a decision, after a hearing, either requiring the employer to pay the physician within thirty-one calendar days in accordance with the medical fee schedule if the treatments are determined to be based upon evidence-based medical treatment guidelines generally recognized by the national medical community and that is scientifically based. In determining the treatment for the claimant, the director will give deference to amendments to the ODG Treatment in Workers' Comp, 3rd Edition, provided the amendments are based on sound scientifically based criteria. Disallowed fees shall not be charged to the injured employee.

(f) For treatments and services by providers of service other than physicians, treatment shall be in accordance with subsection (a) and (b) of this section.

(g) The psychiatric evaluation or psychological testing with the resultant reports shall be limited to four hours unless the physician submits prior documentation indicating the necessity for more time and receives pre-authorization from the employer. Fees shall be calculated on an hourly basis as allowed under Medicare.

(h) For physical medicine, treatments may include up to four procedures, up to four modalities, or a combination of up to four procedures and modalities, and the visit shall not exceed sixty minutes per injury. When treating more than one injury, treatments may include up to six procedures, up to six modalities, or a combination of up to six procedures and modalities, and the entire visit shall not exceed ninety minutes.

(i) Any provider of service who exceeds the treatment guidelines without proper authorization shall not be compensated for the unauthorized services.

(j) No compensation shall be allowed for preparing treatment plans and written justification for treatments which exceed the guidelines.

(k) Failure to comply with the requirements in this section may result in denial of fees.

(l) Treatment, prescribed on an in-patient basis in a licensed acute care hospital where the injured employee's level of care is medically appropriate for an acute setting as determined by community standards, are excluded from the frequency of treatment guidelines specified herein. [Eff 1/1/96; am 1/1/97; am] (Auth: HRS §§386-21, 386-26, 386-72) (Imp: HRS §§386-21, 386-26, 386-27)

§12-15-34 REPEALED [EFF 1/1/96; am 1/1/97; R]

§12-15-85 Rules for allowable fees for medical, surgical, and hospital services and supplies. (a) Under no circumstances shall a provider of service directly charge the injured employee for treatments relating to the industrial injury.

(b) When all the required care for a case reasonably falls within the range of qualifications of one physician, no other physician may claim a fee, except for consultation service or for surgical assistance. For groups of physicians or hospitals with satellite clinics, when service is rendered by a group member of the same specialty, the group shall submit bills as though one physician had cared for the patient.

(c) Medical, surgical, or hospital care of an unusual type or unlisted fee may occur which represents a type of service over and beyond listed procedures. Appropriate fees may be allowed, subject to the employer's approval prior to the service being provided and after submission of a report to the employer containing at least the following information:

(1) Diagnosis (post-operative);
(2) Size, location, and number of lesions or procedures where appropriate;
(3) Major surgical procedure and supplementary procedures;
(4) Estimated follow-up period.

(d) Medical conditions which are pre-existing or not resulting from the injury or occupational disease shall not be compensable. Palliative temporary treatment of unrelated conditions shall be allowed, provided these conditions directly retard, prevent, or endanger the surgical care or recovery from the compensable injury or illness. This treatment will cease as soon as it no longer exerts influence on the compensable condition. This shall be adequately explained in the physician's regular report.

(e) Certain of the listed procedures are commonly carried out as an integral part of a total service and, as such, do not warrant a separate charge. When such a procedure is carried out as a separate procedure, not

immediately related to other services, the indicated fee is applicable.

(f) Minimal dressings, counseling incidental to treatment, etc., are covered by the office visit fee. Necessary drugs, supplies, and materials provided by the provider of service may be charged separately in accordance with section 12-15-55.

(g) Fees, including office visits and rating examinations, shall not be paid for more than one visit per day by the same provider of service regardless of the number of industrial injuries or conditions treated.

(h) Each provider of service shall certify on the bill or charges that such charges are in accordance with chapter 386 HRS, and any related rules. A provider's billing shall be deemed as "certified" under any of the following criteria:

(1) The official billing is on the provider’s official letterhead or billing stationary;

(2) The official billing is accompanied by a signed statement from the provider attesting that the billing is in conformance with Chapter 386, HRS; or

(3) The official billing contains the signature of the provider.

(i) Repeated failure to comply with chapter 386, HRS, and any related rules shall be a reasonable basis for an employer to refuse to pay or withhold payment for services rendered. The employer shall make payment within sixty calendar days of compliance with chapter 386, HRS, and related rules. [Eff 1/1/96; am] (Auth: HRS §§386-21, 386-72) (Imp: HRS §386-21)

DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

Amendments to chapter 12-10 and 12-15, Hawaii Administrative Rules, relating to the Workers' Compensation Law and the Workers' Compensation Medical Fee Schedule, on the Summary Page dated April 20, 2005, were adopted on April 20, 2005, following a public hearing held on February 7, 2005, after public notice was given in the Honolulu Star-Bulletin, Hawaii Tribune-Herald, West Hawaii Today, The Maui News and The Garden Isle on January 7, 2005.

These amendments shall take effect ten days after filing with the Office of the Lieutenant Governor.

NELSON B. BEFITEL
Director
Labor & Industrial Relations

APPROVED AS TO FORM:

Deputy Attorney General

LINDA LINGLE
Governor
State of Hawaii

Date:

Filed

Appendix III

DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

Amendments to Chapter 12-10
Hawaii Administrative Rules
Workers' Compensation Law

April 20, 2005

1. Section 12-10-1, Hawaii Administrative Rules, is amended by amending the definitions of "Able to resume work" and "Attending physician" and adding in new definitions of "Days," "Disciplinary actions", and "Good cause," to read as follows:

""Able to resume work" means an industrially injured worker's injury has stabilized after a period of recovery and the worker is capable of performing work in an occupation for which the worker has received previous training or for which the worker had demonstrated aptitude. [If the worker is unable to perform offered light work, temporary total disability benefits shall not be discontinued based solely on such inability to perform or continue light work.]

"Attending physician" means a physician, as defined in section 386-1, who is primarily responsible for the treatment and direction of care of a work injury. There shall not be more than one attending physician. In the event an injured employee is treated by more than one physician in accordance with section 12-15-40, the employee shall designate a physician as the attending physician.

"Days" means calendar days, unless otherwise provided.

"Disciplinary action" means any action taken in good faith by the employer relating to or used for discipline. Disciplinary action shall include the actual sanction imposed upon an injured employee for the purpose of discipline, as well as any action taken in good faith by an employer that is a part of the disciplinary process, even if no sanction or punishment is ultimately imposed. Examples of

disciplinary actions include, but are not limited to, where the employer takes good faith corrective or punitive action:

(1) to produce a specific type or pattern of behavior;

(2) to obtain conformity;

(3) to train or correct;

(4) to impose order on or improve work habits; and

(5) to impose order on or improve the worksite. If a collective bargaining agreement or other employment agreement specifies a different standard than good faith for disciplinary actions, the standards specified in the agreement shall apply.

"Good Cause" means a compelling reason for failing to perform an act required by law, unless otherwise provided. The party must prove that the failure to perform any act required by law was not due to willful neglect. A finding for good cause will be based upon the circumstances in each case." [Eff: 4/30/81; am 12/17/82; am 11/29/85; am] (Auth: HRS §§386-27, 386-72) (Imp: HRS §§386-1, 386-2, 386-3, 386-21, 386-24, 386-25, 386-27, 386-31, 386-32, 386-42, 386-43, 386-51, 386-71, 386-91, 386-121)

2. Section 12-10-65, Hawaii Administrative Rules, is amended to read as follows:

"**§12-10-65** [**Deposition.** For the purpose of obtaining any matter, not privileged, which is relevant to the subject matter involved in the pending action, the director may, upon application and for good cause, order the taking of relevant testimony by deposition upon oral examination or written interrogatories, or by other means of discovery in the manner and effect prescribed by the Hawaii Rules of Civil Procedure.] **Discovery.** Discovery in workers' compensation cases before the Director is limited to:

(a) **Interrogatories and requests for production of documents.** One set of written interrogatories and requests for production of documents may be served upon each adverse party. The number of

interrogatories, including the requests for production of documents, to any one party shall not exceed 20, each of which shall consist of a single question or request. The responses to the interrogatories and production of documents shall be served on all parties within 20 days of mailing of the interrogatories and requests. The responses to interrogatories and the requests for production of documents may not be submitted to the director later than 15 days prior to hearing.

(b) **Depositions.** For the purpose of obtaining any matter, not privileged, which is relevant to the subject matter involved in the pending action, the director may, upon application, order the taking of relevant testimony by deposition upon oral examination. Permission to take a deposition of a party will be granted only when it is reasonable and necessary such as when there is a specific showing of the following:

(1) That a party who has been served with written interrogatories or requests for production of documents and has failed to respond to the interrogatories or production of documents; or

(2) That the responses to the written set of interrogatories are insufficient; or

(3) All parties agree to the taking of a deposition.

(c) **Subpoenas.**

(1) Subpoenas requiring the attendance of witnesses at a hearing before a hearings officer or for the taking of a deposition or the production of documentary evidence from any place within the State at any designated place of hearing may be issued by the director or a duly authorized representative. The employer shall serve the injured employee with a copy of a medical record subpoena unless the employer has previously obtained the employee's authorization to examine the employee's medical records. Should the employee

subpoena medical records, the employer shall be served with a copy of the medical record subpoena.

(2) The party subpoenaing the records shall serve these records within fifteen calendar days of their receipt upon all other parties. These records shall be submitted by the party requesting the subpoena to the director fifteen days before the date of the hearing or upon request by the director.

(3) A party who desires to enforce the director's subpoena shall seek enforcement from a court of competent jurisdiction.

(d) **Witness fees.** A subpoenaed witness shall be entitled to the same witness fee as in the case of a witness subpoenaed to testify before the circuit court.

(e) **Duty to Supplement.** Each party is under a continuing duty to timely supplement or amend responses to discovery up to the date of the hearing.

(f) **Failure to Comply with Discovery.** If any party fails to comply with this rule and any action governed by it, the director may impose sanctions not to exceed $250.00 for each offense or preclude the party from presenting such evidence at the hearing.

(g) **Additional Discovery.** Upon agreement of the parties or upon showing that discovery is reasonable and necessary, the director may allow additional discovery, may limit discovery, or may modify the time limits set forth in this rule." [Eff: 4/30/81; am 2/11/91; am] (Auth: HRS §386-72) (Imp: HRS §§91-2(2), 386-86)

3. Section 12-10-66, Hawaii Administrative Rules, is amended to read as follows:

"§12-10-66 [Subpoenas. (a) Subpoenas requiring the attendance of witnesses at a hearing before a hearings officer or for the taking of a deposition or the production of documentary evidence from any place within the State at any designated place of hearing may be issued by the director or a duly authorized

representative. The employer shall serve a claimant with a copy of a medical record subpoena unless the employer has previously obtained the claimant's authorization to examine the claimant's medical records. Should the claimant subpoena medical records, the employer shall be served a copy.

(b) The party subpoenaing the records shall provide these records within fifteen calendar days of their receipt to the employer, claimant, the special compensation fund if a joinder has been filed, or their representatives. These records shall be submitted by the party requesting the subpoena to the director within seven calendar days of the date of the "Notice of Hearing" or upon request by the director.

(c) A party who desires to enforce the director's subpoena shall seek enforcement from a court of competent jurisdiction.] **Alternative resolution.** (a) In lieu of a hearing before the Director, at anytime after a claim for compensation is made and before the director renders a decision, the parties may agree in writing to have any controversy arising under this chapter be decided by a referee paid for by the parties.

(b) **Appointment of referee.** Before a referee can conduct a hearing, the parties shall submit the agreed upon referee's name to the Director for appointment to serve as a referee. The referee shall be a neutral person. An individual who has a known, direct, and material interest in the outcome of the controversy or a known, existing, and substantial relationship with a party may not serve as a referee, unless that interest is disclosed, and any conflict is waived by the parties.

(c) **Costs.** Unless the parties otherwise agree, the costs and fees of the alternative resolution process shall be divided equally between the parties.

(d) **Stay of proceedings before the director.** If the parties agree to have any controversy referred to a referee, the director shall stay all actions or proceedings until the director issues a decision based on the referee's recommended decision.

(e) **Discovery and other matters.** Chapter 386 and its rules remain applicable to proceedings before the referee except that requests shall be directed to and recommended decisions shall be made by the referee instead of the director.

(f) **Referee's recommended decision.** The referee shall issue and submit the referee's recommended decision to the Director no later than sixty days after the hearing, and shall deliver the recommended decision to all parties personally or by registered or certified mail.

(g) **Approval of recommended decision.** The Director shall review the referee's recommended decision to determine whether the recommended decision is in compliance with chapter 386. If the recommended decision is in compliance with chapter 386, the Director shall approve the recommended decision and upon the director's approval, the recommended decision has the same force and effect as a director's decision rendered under chapter 386, and it may be enforced as if it had been rendered in an action before the director. If the recommended decision does not comply with chapter 386, the Director may modify or vacate the recommended decision. If the director vacates the recommended decision, the parties may resubmit the controversy to the referee.

(h) **Appeals.** Except when the parties have agreed that no appeal may be taken and where the director has not modified or vacated the referee's recommended decision, the parties may appeal the director's decision in accordance with section 386-87.

(i) **Applicable law.** Chapter 386 and Hawaii Administrative Rules title 12, chapters 10, 14, and 15 are applicable to the proceedings before the referee.

(j) **Mediation.** At anytime after a claim for compensation is made and before the director renders a decision, the parties may agree to resolve any controversy regarding this chapter through mediation by a mediator agreed upon by the parties. Unless otherwise provided in the agreement, the costs and fees of mediation shall be divided equally between the parties. Upon the successful conclusion of the

mediation, the parties shall submit the settlement agreement to the director for approval. If any controversy remains unresolved after the mediation, the parties may request the director resolve the controversy after providing the parties the opportunity to be heard in accordance with chapter 386. [Eff: 4/30/81; am 2/11/91; am] (Auth: HRS §386-72) (Imp: HRS §§91-2(2), 386-86)

4. Section 12-10-67, Hawaii Administrative Rules, is repealed.

["§12-10-67 Witness fees. A subpoenaed witness shall be entitled to the same witness fee as in the case of a witness subpoenaed to testify before the circuit court."] [Eff: 4/30/81; R]

5. Section 12-10-69, Hawaii Administrative Rules, is amended to read as follows:

"§12-10-69 **Attorney's fees.** (a) Within ten calendar days following the filing of a final decision and order or upon the filing of a stipulation and settlement agreement, attorneys seeking approval of fees and costs claims pursuant to section 386-94, HRS, shall file with the department a request for approval of attorney's fees and costs setting forth a detailed breakdown of the time expended and costs incurred in each activity up to and including the date of the decision. The request shall be served on those parties against which the fees and costs claims are to be assessed. Any party objecting to approval of a request may file written objections no later than ten calendar days after service. Absent objections, agreement shall be presumed. No request for approval of attorney's fees and costs claims or agreement to pay attorney's fees and costs claims shall be valid until approved by the director. The director may require additional details and justification of time billed or costs claims. The director shall disapprove requests which are not served properly or filed timely, except for good cause.

(b) [In approving fee requests, the director may consider factors such as: the attorney's skill and experience in Hawaii workers' compensation matters; time and effort required by the complexity of the case; novelty and difficulty of issues; fees awarded in similar cases; benefits obtained for the claimant; hourly rate customarily awarded attorneys possessing similar skill and experience; and fees awarded in compensation cases usually come out of the employee's award.] The director shall determine the maximum allowable hourly rate of the attorney and reasonable time allowable on each workers' compensation case. In approving attorney's fee requests, the director will consider the approved hourly rate of the attorney and the number of hours approved. Factors to be considered in determining an attorney's approved hourly rate include the number of years practicing as an attorney, the number of cases representing workers' compensation claimants during the last three years, and any other pertinent factors that should be considered in determining the hourly rate. Factors considered in determining the number of hours allowable include the time and effort required by the complexity of the case, novelty and difficulty of issues, benefits obtained for the injured employee, and arguments made by the attorney and injured employee. The director reserves the right to adjust the hourly rate and the number of hours requested.

(c) Costs claims such as delivery, typing, telephone (except for long distance calls), fax, and parking are considered part of the cost of doing business and shall not normally be approved unless properly justified. Claims such as photocopying and long distance telephone calls may be approved as costs if properly justified." [Eff: 12/17/82; am 2/11/91; am] (Auth: HRS §386-72) (Imp: HRS §386-94)

6. Chapter 12-10, Hawaii Administrative Rules, is amended by adding a new section 12-10-72.1 to read as follows:

"§12-10-72.1 **Hearings Process.** (a) **Hearings.**

(1) **Requests for hearing.** If the parties are unable to resolve a claim, dispute, or controversy arising under chapter 386, HRS, or these rules, and have been unable to resolve the contested issue informally through mediation or alternative resolution if the parties agreed to submit the matter to mediation or alternative resolution, a party may request a hearing before a hearings officer appointed by the director by filing a written application with the director on a prescribed form. The form shall contain:

(A) A statement of the issue(s) to be determined at the hearing;

(B) A statement setting forth the names and addresses of all witnesses to be presented at the hearing, and/or whose testimony will be submitted by way of a deposition transcript;

(C) A statement notifying the adverse party of their right to file a response to the application within 20 days of the application.

The application for hearing shall be mailed by certified mail by the requesting party to all parties. A certificate of mailing shall be filed with the application. If an attorney has entered an appearance for a party, mailing to the attorney is mandatory. An application will not be accepted for filing unless it contains all information required by this rule and will be returned for corrections.

(2) **Response to Application for Hearing.** Within 20 days from the receipt of the application for hearing, the adverse party shall file its response to the application on a prescribed form with the director and shall send a copy to all parties.

(3) **Scheduling of Hearing.** A hearing shall be held within 60 days after the response is filed with the director or after the date the response is due. If at least 20 days have passed since the application has been filed, and no response has been filed, the claimant may request an expedited hearing upon a showing that without an expedited hearing to determine the merits of the dispute, the claimant will suffer severe economic hardship or severe physical or mental harm.

(4) **Place of Hearing.** All cases within the scope of these rules will be heard in the county where the disputed work injury occurred, unless other arrangements are agreed upon between the parties. The use of electronic hearings utilizing teleconference shall also be authorized if agreed upon by all parties.

(5) **Evidence at hearing.** The admissibility of evidence at the hearing shall not be governed by the rules of evidence, and all relevant oral and documentary evidence shall be admitted. Irrelevant, immaterial, or unduly repetitious material shall not be admitted into evidence. The hearings officer shall give effect to the privileges recognized by law. Documentary evidence may be received in the form of copies, provided that, upon request, all other parties to the proceeding shall be given an opportunity to compare the copy with the original. If the original is not available, a copy may still be admissible, but the unavailability of the original and the reasons therefore shall be considered by the hearings officer when considering the weight of the documentary evidence. The hearings officer may take notice of judicially recognizable facts and of generally recognized technical or scientific facts. The director shall notify

the parties whenever possible before the hearing of the material to be so noticed and the parties shall be afforded an opportunity at the hearing to contest the facts so noticed.

(6) **Witness at Hearing.** A party may not add a witness or an issue after the filing of the application or response except upon agreement of all parties, approval of the hearings officer, or for good cause shown. A party may not produce a witness at a hearing who has not been listed in the application or response or added by agreement or order, except to present rebuttal testimony or upon approval of the hearings officer for good cause shown.

(7) **Continuance of Hearing.** At any time following the scheduling of the hearing, any party may, by written motion, seek an extension of time to commence a hearing upon good cause shown. For the purpose of this paragraph, good cause includes, but is not limited to, the following:

(A) Death or incapacitation of a party or an attorney for a party;

(B) Entry or substitution of an attorney for a party a reasonable time prior to the hearing, if the entry or substitution reasonably requires an extension;

(C) Failure of a witness to appear when the witness is under a valid subpoena, which will result in prejudicing one of the parties;

(D) A showing that more time is clearly necessary to complete authorized discovery or other necessary preparation for the hearing; or

(E) Agreement of the parties that a settlement has been reached, or that settlement negotiations are ongoing and likely to be reached.

Absent additional grounds, failure of the party to timely or adequately prepare for the hearing does not constitute good cause.

(8) **Submission of reports, other documentary evidence, depositions, position statements for formal hearing.** All reports without limitation including medical and hospital reports, physicians' reports, vocational reports, and records of the employer shall be filed with the director and sent to all parties at least 15 days prior to the hearing. If not so disclosed, the reports shall not be introduced into evidence at the hearing, absent a showing of good cause. Reports and records previously provided to opposing parties do not have to be provided again. When provided, such reports and records do not have to be identified as potential hearing exhibits. A deposition transcript shall be filed 15 days before the hearing. Oral arguments at the conclusion of the hearing may be allowed at the discretion of the hearings officer. A party may file a position statement and/or proposed order upon approval of the hearings officer. Only reports and records filed and identified at the hearing which are relevant to an issue set for hearing will be considered as evidence. Testimony presented by reports, records, deposition, or teleconference is presumed to be equivalent of in person hearing testimony.

(9) **Hearing Electronically Recorded.** For quality assurances, every hearing shall be electronically recorded. Any party in the action may request a recorded copy of the hearing. The cost of the recorded copy of the hearing is five dollars, payable to the department.

(b) **Powers of the hearings officer in conducting hearing.** The hearings officer shall have, in addition

to powers as are conferred by law, the powers in conducting a hearing without limitation:

(1) To hold hearings and issue notices;

(2) To administer oaths and affirmations;

(3) To consolidate hearings or sever proceedings, provided that those actions shall be conducive to the ends of justice and shall not unduly delay the proceedings or hinder, harass, or prejudice any party;

(4) To allow and supervise discovery as deemed reasonable and necessary;

(5) To subpoena and examine witnesses;

(6) To receive relevant evidence, and to exclude evidence which is irrelevant, immaterial, repetitious, or cumulative, and accordingly may restrict lines of questioning or testimony;

(7) To regulate the course and conduct of the hearing;

(8) To regulate the manner of any examination so as to prevent the needless and unreasonable harassment or intimidation of any witness or party at the hearing;

(9) To remove disruptive individuals, including any party, legal counsel, witness, or observer;

(10) To hold conferences, including prehearing conferences, before or during the hearing for the settlement or simplification of issues; and

(11) With the exception of scheduling or other purely administrative matters, a hearings officer presiding over the matter shall not initiate any oral communication with a party or counsel for a party unless prior written consent of all other parties or their counsel has been obtained.

(c) **Burden of Proof.** With the exception of those controverted cases that fall under section 386-85, HRS, where the burden of proof lies with the employer, the burden of proof for all other

controverted cases shall lie with the party filing for hearing.

(d) **Decision on the record.** If the director determines that there is no material fact in dispute as to any contested issue, the director may elect to render a decision on the record. When the director determines that a decision on the record is appropriate, the parties shall be given 20 days to submit written statements and evidence. Ten additional days shall be given to respond. At the discretion of the director, additional time may be allowed for good cause. Copies of all written statements and evidence shall be furnished to the department and all parties.

The director shall issue a decision within 15 working days from the date the responses are filed. Request for review of a decision on the record shall be made pursuant to section 386-87, HRS.

(e) **Appeals process.**

(1) A decision of the director shall be final and conclusive between the parties, except as provided in section 386-89, HRS, unless within twenty days after a copy has been sent to each party, either party appeals therefrom to the appellate board by filing a written notice of appeal with the appellate board or the department. In all cases of appeal filed with the department the appellate board shall be notified of the pendency thereof by the director. No compromise shall be effected in the appeal except in compliance with section 386-78.

(2) The appellate board shall hold a full hearing de novo on the appeal.

(3) The appellate board shall have power to review the findings of fact, conclusions of law and exercise of discretion by the director in hearing, determining or otherwise handling of any compensation case and may affirm, reverse or modify any compensation case upon review, or remand the

case to the director for further proceedings and action.

(4) In the absence of an appeal and within thirty days after mailing of a certified copy of the appellate board's decision or order, the appellate board may, upon the application of the director or any other party, or upon its own motion, reopen the matter and thereupon may take further evidence or may modify its findings, conclusions or decisions. The time to initiate judicial review shall run from the date of mailing of the further decision if the matter has been reopened. If the application for reopening is denied, the time to initiate judicial review shall run from the date of mailing of the denial decision." [Eff:] (Auth: HRS §386-72) (Imp: HRS §§91-2(2), 386-86)

7. Chapter 12-10-94, Hawaii Administrative Rules, is amended to read as follows:

"12-10-94 Self-insurance; application; duration; cancellation; revocation.

(a) Application.

(1) An employer desiring to maintain security for payment of compensation under section 386-121(a)(3), HRS, shall file [an]:

(A) An application with the director on a form provided for this purpose. [together with its]

(B) The most current audited annual financial statement with an unqualified audit opinion for a period not more than one year of the date of the application.

(C) Audited annual financial statements for the previous three years conducted in accordance with generally accepted accounting and auditing principles.

(D) A copy of the resolution of the applicant corporation board of directors authorizing the filing of the application for a certificate of consent to self-insurance and execution of the instrument of undertaking in furnishing security if required.

(E) An actuarially determined annual workers' compensation future liabilities of the applicant, prepared by a Member of the American Academy of Actuaries or other qualified loss reserve specialist approved by the director.

[(b)] (2) Where an applicant for self-insurance is a subsidiary and the subsidiary cannot submit an independent current audited annual financial statement with an unqualified audit opinion, in lieu thereof an indemnity agreement approved as to form and content by the director shall be executed by the parent corporation of the subsidiary and submitted with its application.

(3) The financial statements must demonstrate the applicant's financial solvency. To detect any unique or extraordinary circumstances facing the applicant, factors considered in financial analysis include, but are not limited to, operating income for the last five years, positive retained earnings, no adverse substantial statements in the notes to the financial statements, and a favorable Altman "Z" score. Furthermore, ratios derived from the applicant's financial statements must compare favorably to the industry averages. Ratios examined include, but are not limited to liquidity ratios, coverage ratios, leverage ratios, and operating ratios.

(4) The ability to pay workers' compensation benefits means sufficient financial strength and stability to pay obligations as they

mature; pay compensation benefits and all liabilities which are likely to be incurred under the Hawaii Workers' Compensation Law; and have sufficient cash or cash equivalents, security deposit, and excess insurance to make benefit and compensation payments as they come due. The ability to pay shall be established by the maintenance of a trust account by the applicant in the amount of the actuarially determined annual workers' compensation liabilities of the applicant.

(5) Failing to demonstrate financial solvency, the applicant may still pursue self-insurance under section 386-121(a)(2) by providing a security deposit in an amount equal to the greater of $1,000,000 or 1.5 times the actuarially determined annual workers' compensation future liability of the applicant. The security deposit may be a surety bond, government bond, letter of credit, or certificate of deposit acceptable by the director. All forms of security shall name the director as beneficiary. When a security deposit is required, the following criteria shall apply:

(A) The director shall accept a surety bond only from companies certified by the United States department of treasury as "Companies Holding Certificates of Authority as Acceptable Sureties on Federal Bonds and as Acceptable Reinsuring Companies," as published in the Federal Register.

(B) The security deposit must name the director as obligee and must be held by the director as security for payment of all workers' compensation liabilities. The director shall retain a security deposit until all liabilities have been paid. The director shall, at its

discretion, convert the deposit needed to pay claims.

(C) A security deposit in the form of a surety bond or letter of credit must include a statement that the grantor of the security deposit is required to give to the principal, the director, 60 days notice of its intent to terminate future liability. The grantor of the security deposit is not relieved of liability for injuries occurring prior to the effective date of termination. A Letter of Credit must be issued by a state chartered bank or member of the Federal Reserve System.

(6) Specific excess insurance is required of a self-insured employer. Aggregate excess insurance is required by the director for an employer unless substantive evidence is provided that it is not warranted. This evidence must include diversification of risk, industry type, financial resources, self-insured retention levels, policy limits of the specific excess policy, safety program, loss experience and other appropriate factors as determined relevant by the director.

The contract or policy of specific excess insurance and aggregate excess insurance must comply with the following:

(A) It is issued by a carrier licensed in Hawaii with a Best's Rating of A- or better and a financial size rating of VI or greater. Excess coverage issued by a carrier not rated by Best's will be considered for approval at the discretion of the director.

(B) It may be cancelled or its renewal denied only upon written notice by registered or certified mail to the other party to the policy and to the director not less than 60 days before

termination by the party desiring to cancel or not renew the policy. A carrier is liable for payment of all claims that occur from the date of inception of the policy to the cancellation date of the policy.

(C) Any contract containing a commutation clause must provide that any commutation effected thereunder will not relieve the underwriter(s) of further liability in respect to claims and expenses unknown at the time of such commutation or in regard to any claim apparently closed at the time of initial commutation which is subsequently reopened by the director or a court. If the underwriter proposes to settle the liability as provided in the commutation clause of the policy for future compensation benefits payable for accidents occurring during the term of the policy by the payment of a lump sum to the self-insurer, then not less than 60 days prior notice to such commutation must be given by the underwriter(s) or agent(s); by registered or certified mail to the director. If any commutation is effected, the director shall have the right to direct such sum be placed in trust for payment of benefits of the injured employee(s) entitled to such future payments.

(D) If a self-insurer becomes insolvent and/or fails to make benefit payments, the excess carrier, after it has been determined the retention level has been reached on the excess insurance policy, shall make payments to the entity making payments on behalf of the insolvent self-insured in the same manner as payments would have been made

by the excess carrier of the self-insured.

(E) All of the following will be applied toward the retention level in the excess insurance contract:

(i) payments made by the self-insurer;

(ii) payments made on behalf of the self-insurer from the proceeds of any security deposit as ordered by the department; and

(iii) payments made on behalf of the insolvent self-insurer by the Special Compensation Fund.

(F) Copies of the certificates and policies of the excess insurance must be filed with the department for a determination that such certificates and policies are approved by the insurance commissioner.

(7) An applicant must retain an adjustor licensed under chapter 431, HRS, to provide complete claims service to process and promptly pay claims in accordance with chapter 386, HRS.

(8) Upon approval of the self-insurance status, an Order for Self-Insurance shall be issued to the applicant and this order must be conspicuously posted at the applicant's worksite.

(b) **Duration.**

[(c)](1) Each self-insurance authorization shall be effective from date of issue to June 30 of each calendar year.

(2) The self-insurer is liable for the charges into the workers' compensation special compensation fund pursuant to section 386-154.

(3) Annual submission and review of self-insurer's audited financial statements are required for continuation of the self-insurer's self-insurance status. The most recent audited financial statement, prepared

in accordance with generally accepted accounting and auditing principles, for a period ending not more than twelve months prior to June 30 of the current year, must be submitted on or before April 1 of each year.

[(d)](c) **Cancellation.** A notice of intention to cancel self-insurance shall be submitted in writing to the director within at least thirty days prior to the effective date of cancellation. If a security deposit is required pursuant to section 12-10-94(a)(4) above, this security deposit must be maintained at least twenty four months after termination of self-insurance status, provided all workers' compensation claims occurring during the period of self-insurance and workers' compensation special compensation fund assessments pursuant to section 386-154, HRS have been paid.

[(e)](d) **Revocation.** A self-insurance authorization may be revoked by the director [for good cause] upon notification in writing to the self-insurer[.], if the self-insurer fails to meet its obligation to pay workers' compensation benefits resulting from work injuries during the period of self-insurance or if the self-insurer fails to demonstrate financial solvency and ability to pay workers' compensation benefits." [Eff: 4/30/81; am] (Auth: HRS §386-72) (Imp: HRS §§91-2, 386-121)

8. Material, except source notes, to be repealed is bracketed. New material is underscored.

9. Additions to update source notes to reflect these amendments are not underscored.

10. These amendments to Title 12, Chapter 10, Hawaii Administrative Rules, relating to the Hawaii Workers' Compensation Law shall take effect ten days after filing with the Office of the Lieutenant Governor.

I certify that the foregoing are copies of the rules drafted in the Ramseyer format, pursuant to the requirements of section 91-4.1, Hawaii Revised Statutes, which were adopted on ( ) and filed with the Office of the Lieutenant Governor.

Director

APPROVED AS TO FORM:

Deputy Attorney General

Appendix IV

DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

Amendments to Chapter 12-15
Hawaii Administrative Rules
Workers' Compensation
Medical Fee Schedule

April 20, 2005

1. Section 12-15-1, Hawaii Administrative Rules, is amended by adding one new definition to read as follows:

""Evidence based" means the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual injured employees entitled to benefits." [Eff 1/1/96; am] (Auth: HRS §§386-21, 386-26, 386-27, 386-72) (Imp: HRS §§386-1, 386-2, 386-21, 386-23, 386-27)

2. Section 12-15-30, Hawaii Administrative Rules, is amended by amending subsection (d) to read as follows:

"(d) Frequency of treatment specified in the rules herein are guidelines to improve provider of service accountability and are [not] intended to be [an] the [authoritative] presumptive prescription for health care[.], subject to the provisions of §12-15-32." [Eff 1/1/96; am] (Auth: HRS §§386-26, 386-27, 386-72) (Imp: HRS §§386-21, 386-26, 386-27, 386-94, 386-96)

3. Section 12-15-31, Hawaii Administrative Rules, is amended by amending subsection (c) to read as follows:

"(c) Any service performed by a provider of service who is not a physician as defined in section 386-1, HRS, shall be referred by and be under the direction of the attending physician. [Treatment may be rendered on the basis of a written prescription and treatment plan approved by the attending physician as

specified in section 12-15-34. The prescription and treatment plan shall be individualized for the patient's industrial injury.] All treatment and prescription shall be in writing and in accordance with §12-15-30 and §12-15-32." [Eff 1/1/96; am] (Auth: HRS §§386-21, 386-26, 386-27, 386-72) (Imp: HRS §§386-21, 386-26, 386-27)

4. Section 12-15-32, Hawaii Administrative Rules, is amended to read as follows:

"§12-15-32 [Physicians.] Providers of service. (a) [Frequency and extent of treatment shall not be more than the nature of the injury and the process of a recovery requires. Authorization is not required for the initial fifteen treatments of the injury during the first sixty calendar days.] Frequency and extent of treatment shall be in accordance with the ODG Treatment in Workers' Comp, 3rd Edition, issued by the Work Loss Data Institute. In addition to the ODG Treatment in Workers' Comp, 3rd Edition, the director references Chapters 1-7 of the practice guides issued by the American College of Occupational and Environmental Medicine, 2nd Edition, as an expression of disability management philosophy that should be an integral part of practice within the workers' compensation system, and as an educational tool for health care providers and other participants practicing in the workers' compensation system. The treatment guidelines adopted in this subsection are presumed medically necessary and correct. The presumption is rebuttable and may be contested by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of the injury condition.

The attending physician, in addition to submitting the initial report, in accordance with section 386-96, HRS, shall submit on a form prescribed by and to be obtained from the department, entitled "Restorative Services Plan." The "Restorative Services Plan" shall include the following:

(1) Physical or mental functions necessary to perform job duties;

(2) Identify the functional deficits caused by the injury;
(3) Identify the minimal functional level to be attained in order to return to work;
(4) Provide a treatment protocol;
(5) Provide a timeline for treatment outcome; and
(6) Other pertinent information.

(b) [If the physician believes treatments in addition to that allowed by subsection (a) are required, the physician shall mail a treatment plan to the employer under separate cover at least seven calendar days prior to the start of the additional treatments. A treatment plan shall be for one hundred twenty calendar days and shall not exceed fifteen treatments within that period. Treatments provided with less than seven calendar days notice are not authorized. A complete treatment plan shall contain the following elements:

(1) Projected commencement and termination dates of treatment;
(2) A clear statement as to the impression or diagnosis;
(3) A specific time schedule of measurable objectives to include baseline measurements at the start of the treatment plan and projected goals by the end of the treatment plan;
(4) Number and frequency of treatments;
(5) Modalities and procedures to be used; and
(6) An estimated total cost of services.

Treatment plans which do not include the above specified elements but which are reasonable and necessary may not be denied by the employer, but upon written notification from the employer, the physician shall correct the deficiency(s) and the employer's liability is deferred as long as the treatment plan remains deficient. Neither the injured employee nor the employer shall be liable for services provided under a treatment plan that remains deficient. Both the front page of the treatment plan and the envelope in which the plan is mailed shall be clearly identified as a "WORKERS' COMPENSATION TREATMENT PLAN" in capital

letters and in no less than ten point type.] For all injuries not covered by the ODG Treatment in Workers' Comp, 3rd Edition, or in cases in which the attending physician believes that additional treatments beyond that provided by subsection (a) are necessary or that a treatment guideline different than that specified in subsection (a) is necessary, the attending physician shall mail a treatment plan to the employer at least fourteen calendar days prior to the start of the additional or differing treatments. The treatment plan shall detail:

(1) The attending physician's explanation for deviation from the guidelines established under §12-15-32(a), and that the plan is based upon evidence-based medical treatment guidelines generally recognized by the national medical community and that is scientifically based;

(2) That the proposed treatment plan and guidelines were developed by physicians, with involvement of actively practicing health care providers and are peer-reviewed;

(3) Projected commencement and termination dates of treatment;

(4) A clear statement as to the impression or diagnosis;

(5) Number and frequency of treatments;

(6) Modalities and procedures to be used; and

(7) An estimated total cost of services.

No treatment plan shall be valid that is not based upon evidence-based medical treatment guidelines generally recognized by the national medical community and that is scientifically based. With the exception of emergency medical services, any provider of services who exceeds the treatment guidelines without proper authorization shall be denied compensation for the unauthorized services. Unless agreed by the employee, disallowed fees shall not be charged to the injured employee.

(c) The employer may file an objection to the treatment guideline or proposed treatment plan with

documentary evidence supporting the denial and a copy of the denied treatment plan with the director, copying the attending physician and the injured employee. Both the front page of the denial and the envelope in which the denial is filed shall be clearly identified as a "TREATMENT PLAN DENIAL" in capital letters [and in no less than ten point type]. The employer shall be responsible for payment for treatments provided under a complete treatment plan until the date the objection is filed with the director. Furthermore, the employer's objection letter must explicitly state that if the attending physician or the injured employee does not agree with the denial, they may request a review by the director of the employer's denial within fourteen calendar days after postmark of the employer's denial, and failure to do so shall be construed as acceptance of the employer's denial.

In denying medical treatment, the employer must disclose to the attending physician and employee the medically, evidenced-based criteria used as the basis of the objection.

(d) The attending physician or the injured employee may request in writing that the director review the employer's denial of the treatment plan. The request for review shall be filed with the director, copying the employer, within fourteen calendar days after postmark of the employer's denial. A copy of the denied treatment plan shall be submitted with the request for review. Both the front page of the request for review and the envelope in which the request is filed shall be clearly identified as a "REQUEST FOR REVIEW OF TREATMENT PLAN DENIAL" in capital letters [and in no less than ten point type]. For cases not under the jurisdiction of the director at the time of the request, the injured employee shall be responsible to have the case remanded to the director's jurisdiction. Failure to file a request for review of the employer's denial with the director within fourteen calendar days after postmark of the employer's denial shall be deemed acceptance of the employer's denial. The recommended guidelines set forth in the ODG Treatment in Workers' Comp, 3rd Edition, and American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, 2nd Edition,

shall be presumptively correct on the issue of extent and scope of medical treatment and utilization, regardless of date of injury. The presumption is rebuttable and may be contested by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of the injury condition.

(e) The director shall issue a decision, after a hearing, either requiring the employer to pay the physician within thirty-one calendar days in accordance with the medical fee schedule if the treatments are determined to be [reasonable and necessary or disallowing the fees for treatments determined to be unreasonable or unnecessary. Disallowed fees shall not be charged to the injured employee.] based upon evidence-based medical treatment guidelines generally recognized by the national medical community and that is scientifically based. In determining the treatment for the claimant, the director will give deference to amendments to the ODG Treatment in Workers' Comp, 3rd Edition, provided the amendments are based on sound scientifically based criteria. Disallowed fees shall not be charged to the injured employee.

(f) [The decision issued pursuant to subsection (e) shall be final unless appealed pursuant to section 386-87, HRS. The appeal shall not stay the director's decision.] For treatments and services by providers of service other than physicians, treatment shall be in accordance with subsection (a) and (b) of this section.

(g) The psychiatric evaluation or psychological testing with the resultant reports shall be limited to four hours unless the physician submits prior documentation indicating the necessity for more time and receives pre-authorization from the employer. Fees shall be calculated on an hourly basis as allowed under Medicare.

(h) For physical medicine, treatments may include up to four procedures, up to four modalities, or a combination of up to four procedures and modalities, and the visit shall not exceed sixty minutes per injury. When treating more than one injury, treatments may include up to six procedures, up to six modalities, or a combination of up to six procedures and

modalities, and the entire visit shall not exceed ninety minutes.

(i) Any [physician] provider of service who exceeds the treatment guidelines without proper authorization shall not be compensated for the unauthorized services.

(j) No compensation shall be allowed for preparing treatment plans and written justification for treatments which exceed the guidelines.

(k) Failure to comply with the requirements in this section may result in denial of fees.

(l) Treatment, prescribed on an in-patient basis in a licensed acute care hospital where the injured employee's level of care is medically appropriate for an acute setting as determined by community standards, are excluded from the frequency of treatment guidelines specified herein." [Eff 1/1/96; am 1/1/97; am] (Auth: HRS §§386-21, 386-26, 386-72) (Imp: HRS §§386-21, 386-26, 386-27)

5. Section 12-15-34, Hawaii Administrative Rules, is repealed.

["§12-15-34 Providers of service other than physicians.

(a) Frequency and extent of treatment shall not be more than the nature of the injury and the process of a recovery require. Any health care treatment or service performed by a Hawaii licensed or certified provider of service other than a physician shall be directed by the attending physician based on a written prescription signed, dated, and approved by the attending physician. The prescription may authorize up to an initial fifteen treatments of the injury during the first sixty calendar days. For therapists, the prescription may authorize up to an initial twenty treatments of the injury during the first sixty calendar days.

(b) If the attending physician believes treatments in addition to that allowed by subsection (a) are required, the provider of service other than a physician, in lieu of the attending physician, may mail a treatment plan for review and approval to the attending physician who shall, after approval, mail the treatment plan to the employer under separate cover at

least seven calendar days prior to the start of the additional treatments. A treatment plan shall be for one hundred twenty calendar days and shall not exceed fifteen treatments within that period. Treatments provided with less than seven calendar days notice are not authorized. A complete treatment plan shall contain the following elements:

(1) Projected commencement and termination dates of treatment;
(2) A clear statement as to the impression or diagnosis;
(3) A specific time schedule of measurable objectives to include baseline measurements at the start of the treatment plan and projected goals by the end of the treatment plan;
(4) Number and frequency of treatments;
(5) Modalities and procedures to be used; and
(6) An estimated total cost of services.

Treatment plans which do not include the above specified elements but which are reasonable and necessary may not be denied by the employer, but upon written notification from the employer, the physician or the provider of service, with approval by the attending physician, shall correct the deficiency(s) and the employer's liability is deferred as long as the treatment plan remains deficient. Neither the injured employee nor the employer shall be liable for services provided under a treatment plan that remains deficient. Both the front page of the treatment plan and the envelope in which the plan is mailed shall be clearly identified as a "WORKERS' COMPENSATION TREATMENT PLAN" in capital letters and in no less than ten point type.

(c) The employer may file an objection to the treatment plan with documentary evidence supporting the denial and a copy of the denied treatment plan with the director, copying the attending physician, the provider of service and the injured employee. Both the front page of the denial and the envelope in which the denial is filed shall be clearly identified as a "TREATMENT PLAN DENIAL" in capital letters and in no less than ten point type. The employer shall be responsible for payment for treatments provided under a complete

treatment plan until the date the objection is filed with the director. Furthermore, the employer's objection letter must explicitly state that if the attending physician or the injured employee does not agree with the denial, they may request a review by the director of the employer's denial within fourteen calendar days after postmark of the employer's denial, and failure to do so shall be construed as acceptance of the employer's denial.

(d) The attending physician or the injured employee may request in writing that the director review the employer's denial of the treatment plan. The request for review shall be filed with the director, copying the employer, within fourteen calendar days after postmark of the employer's denial. A copy of the denied treatment plan shall be submitted with the request for review. Both the front page of the request for review and the envelope in which the request is filed shall be clearly identified as a "REQUEST FOR REVIEW OF TREATMENT PLAN DENIAL" in capital letters and in no less than ten point type. For cases not under the jurisdiction of the director at the time of the request, the injured employee shall be responsible to have the case remanded to the director's jurisdiction. Failure to file a request for review of the employer's denial with the director within fourteen calendar days after postmark of the employer's denial shall be deemed acceptance of the employer's denial.

(e) The director shall issue a decision, after a hearing, either requiring the employer to pay the provider of service other than a physician within thirty-one calendar days in accordance with the medical fee schedule if the treatments are determined to be reasonable and necessary or disallowing the fees for treatments determined to be unreasonable or unnecessary. Disallowed fees shall not be charged to the injured employee.

(f) The decision issued pursuant to subsection (e) shall be final unless appealed pursuant to section 386-87, HRS. The appeal shall not stay the director's decision.

(g) The provider of service other than a physician shall submit reports at least monthly to the attending physician and employer regarding an injured

employee's progress. The preparation and submission of written reports or progress notes to the employer by the provider of service other than a physician are an integral part of the service fee.

(h) Treatments may include up to four procedures, up to four modalities, or a combination of up to four procedures and modalities, and the visit shall not exceed sixty minutes per injury. When treating more than one injury, treatments may include up to six procedures, up to six modalities, or a combination of up to six procedures and modalities, and the entire visit shall not exceed ninety minutes. This section applies to providers of service other than physicians including physical therapists, occupational therapists, massage therapists, and acupuncturists.

(i) Any provider of service other than a physician who exceeds the treatment guidelines without proper authorization shall not be compensated for the unauthorized services.

(j) No compensation shall be allowed for preparing treatment plans and written justification for treatments which exceed the guidelines.

(k) Failure to comply with the requirements in this section may result in denial of fees.

(l) Therapy by physical therapists and occupational therapists, prescribed on an in-patient basis in a licensed acute care hospital where the injured employee's level of care is medically appropriate for an acute setting as determined by community standards or, prescribed on an out-patient post-surgery basis not to exceed thirty calendar days, are excluded from the frequency of treatment guidelines specified herein."] [Eff 1/1/96; am 1/1/97; R]

6. Section 12-15-85, Hawaii Administrative Rules, is amended by amending subsection (h) to read as follows:

"(h) Each provider of service shall certify on the bill or charges that such charges are in accordance with chapter 386 HRS, and any related rules. A provider's billing shall be deemed as "certified" under any of the following criteria:

(1) The official billing is on the provider's official letterhead or billing stationary;
(2) The official billing is accompanied by a signed statement from the provider attesting that the billing is in conformance with Chapter 386, HRS; or
(3) The official billing contains the signature of the provider." [Eff 1/1/96; am] (Auth: HRS §§386-21, 386-72) (Imp: HRS §§386-21)

§§386-21, 386-26)

7. Material, except source notes, to be repealed is bracketed. New material is underscored.

8. Additions to update source notes to reflect these amendments are not underscored.

9. These amendments to Title 12, Chapter 15, Hawaii Administrative Rules, relating to the Hawaii Workers' Compensation Medical Fee Schedule shall take effect ten days after filing with the Office of the Lieutenant Governor.

I certify that the foregoing are copies of the rules drafted in the Ramseyer format, pursuant to the requirements of section 91-4.1, Hawaii Revised Statutes, which were adopted on ( ) and filed with the Office of the Lieutenant Governor.

Nelson B. Befitel
Director

APPROVED AS TO FORM:

Deputy Attorney General